U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

AN ASSESSMENT OF INNOVATIVE MODELS OF PEER SUPPORT SERVICES IN BEHAVIORAL HEALTH TO REDUCE PREVENTABLE ACUTE HOSPITALIZATION AND READMISSIONS

December 2015

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This report was prepared under contract #HHSP23320100026WI between HHS's ASPE/DALTCP and Westat. For additional information about this subject, you can visit the DALTCP home page at https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp or contact the ASPE Project Officer, Joel Dubenitz, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. His e-mail address is: Joel.Dubenitz@hhs.gov.

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

A1c	Glycated Hemoglobin
ABHW	Association for Behavioral Health and Wellness
ACA	Affordable Care Act
ACG	Appalachian Consulting Group
ACMHA	American Mental Health Counselors Association
ACT	Assertive Community Treatment
CFR	Code of Federal Regulations
CMS	HHS Centers for Medicare and Medicaid Services
CPR	Cardiopulmonary Resuscitation
CRT	Community Response Team
CTI	Critical Time Intervention
DBSA	Depression and Bipolar Support Alliance
ED	Emergency Department
GED	General Equivalency Diploma
GEP	Grassroots Empowerment Project
GMHCN	George Mental Health Consumer Network
HARP	Health and Recovery Peer
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	HHS Health Resources and Services Administration
IOM	Institution of Medicine
iNAPS	International Association of Peer Specialists
IPS	Intentional Peer Support
ITA	Involuntary Treatment Act
JACO	Joint Commission on Accreditation of Healthcare Organizations
MHASP	Mental Health Association of Southeast Pennsylvania
NYAPRS	New York Association for Psychiatric Rehabilitation Services
OMH	New York Office of Mental Health

PEOPLe	Projects to Empower and Organize the Psychiatrically Labeled
PORCH	Permanent Options for Recovery-Centered Housing
PSS	Peer Support Services
PSW	Peer Support Worker
PSWC	Peer Support Wellness Center
RBHA	Regional Behavioral Health Authority
RCT	Randomized Controlled Trial
RI	Recovery Innovations
RSN	Regional Support Network
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illnesses
STRAWW	Southern Tier Recovery Activities Without Walls
SUD	Substance Use Disorder
VA	U.S. Department of Veterans Affairs
WHAM	Whole Health Action Management
WRAP	Wellness Recovery Action Plan

EXECUTIVE SUMMARY

Recurrent psychiatric hospitalizations and emergency department (ED) utilization is common among those with serious mental illnesses and others with behavioral health conditions. The result is excessively high health care costs, and in some cases preventable overuse of services. Peer support services (PSS) are a recognized part of team-based care for behavioral health conditions, and peer support specialists are currently reimbursed for these service in Medicaid plans in a majority of states. This study, funded by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, examines the role of PSS in reducing unnecessary psychiatric hospital admissions and ED utilization.

Three research questions frame the study and examine:

1. The approaches, models, and practice methods that are used to reduce preventable psychiatric hospitalization, re-hospitalization, and ED use.

2. The extent to which these models are being utilized across health systems, states, counties, cities, and other organizational networks.

3. The structural supports for these innovative practices including funding, training, and other requirements as offered through or outside the behavioral health care system.

This document is the final report for the study. It includes information from the study literature review, key informant interviews, and site visits to four exemplary PSS programs.

This final report is broken into chapters to enable readers to jump to the information that they are most interested in. The chapters can be read individually and can stand alone in terms of information and structure. Read together, the chapters provide a comprehensive look at the research questions.

The chapters within this report focus on the following:

Chapter 1: Environmental Scan of Peer Support Services. This chapter includes a literature review of the evidence base for PSS and the deployment of this workforce in behavioral and integrated health services. Key informant interviews are also included in the findings of the environmental scan report. It is important to note that the environment scan was conducted as a first step in the study, before sites were identified for site visits. The environmental scan shaped the selection of the four PSS sites; the questions asked of the sites; and the data collected using the site visit protocols.

The environmental scan includes a proposed framework for three levels of PSS that could impact preventable hospital and ED utilization. The levels include crisis-based and respite-based PSS, level of care transitions programs, and community-based recovery oriented services. This framework is used to examine services across four different peer service programs.

Chapter 2: Site Selection. This chapter focuses on the selection criteria for the four exemplary PSS programs included in this study.

Chapter 3: Site Visit Case Studies. This section contains brief case study reports that provide uniformly formatted information gathered from the four exemplary sites. These case studies are structured to provide parallel information on the key variables included in the study. The site visit case studies include Georgia Mental Health Consumer Network; New York Association of Psychiatric Rehabilitation Services; Optum's Pierce County (Washington State) Regional Support Network; and Recovery Innovations.

Chapter 4: Case Study Findings and Conclusions. This section provides the findings from the site visits, areas that require further investigation and development, and next steps for the field. The results of this study identify PSS as a viable resource to help reduce unnecessary psychiatric hospital services and ED utilization. Services provided across the three-tier framework show promising results for improving the outcomes and reducing the costs of care. However, limited data collection and the absence of rigorous outcome evaluations limit the confidence in these conclusions. Variable results are noted across programs, and opportunities for expanded program evaluations are noted.

1. ENVIRONMENTAL SCAN REPORT

In recent years, the peer support services (PSS) workforce has evolved to become an essential part of mental health and addiction treatment, family support, and primary care services. In 2003, the President's New Freedom Commission for Mental Health recommended expanded integration of PSS into the behavioral health treatment system. Interest and utilization of PSS was further bolstered by a 2007 letter to state Medicaid directors in which the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) identified PSS as evidence-based practice and approved coverage of PSS under Medicaid funding (CMS, 2007).

The implementation of the Affordable Care Act (ACA) and corresponding changes in the delivery of health care services generally provide additional opportunities to develop and integrate PSS across the health care system. Despite the growing number of PSS providers and the growing interest in these services, there is limited information about the impact of PSS on medical costs and, specifically, hospital admission and readmission rates.

The purpose of this study, funded by the HHS Office of the Assistant Secretary for Planning and Evaluation, is to examine innovative practices in PSS designed to bolster patient stability in the community and reduce preventable hospital admission, readmission, and emergency department (ED) utilization for behavioral health conditions. This project seeks to identify existing and emerging innovations; evidence supporting the use of these models; and options facilitating further adoption.

An environmental scan of PSS provides a review of the role of these services in health care and their evolving deployment to improve health outcomes. Information in this environmental scan was compiled through traditional literature searches, Internet searches, and key informant discussions with PSS leaders, researchers, and peer support specialists. This report is focused on answering the following research questions:

1. What PSS approaches, models (and/or components of models), or methods of practice demonstrate the most promise toward reducing preventable psychiatric hospitalization, re-hospitalization, and ED use?

2. To what extent are these models being utilized in the United States and at what level of the system (e.g., states, counties, cities, organizational networks)?

3. What are the structural supports for these innovative practices -- including funding, training, and credentialing requirements -- offered through or outside the behavioral health care system?

A three-level framework for how PSS help address the research questions in this study is also presented.

Peer Support Services

Many definitions of PSS are found across published literature, state websites, and federal websites. The Pillars of Peer Support initiative has also defined the key principles and characteristics of PSS (Daniels, Bergeson, Fricks, Ashenden, and Powell, 2012). The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) has been a leader within the Federal Government for promoting the use of PSS nationally. For the purposes of this study, we use the SAMHSA definition.

SAMHSA defines PSS as specialized assistance that is delivered by a person in recovery from an serious mental illnesses (SMI), substance use, or co-occurring mental and substance use condition, before, during, and after treatment to facilitate a recipient's long-term recovery in the community (Chinman, George, Dougherty, Daniels, Ghose, Swift, and Delphin-Rittmon, 2014). The goal of these services is to assist with the development of strategies to promote coping, problem-solving, and self-management of a person's behavioral health condition. This is accomplished by the peer support specialist drawing upon his/her own lived experiences and empathy to help others by promoting hope, developing skills and insights, fostering treatment engagement, accessing community supports, and building a satisfying life.

Key Definitions of Terms Used in This Report

Peers

Within the mental health and/or substance use field, this term is used to refer to someone who has experienced a behavioral health condition firsthand and is now in recovery from a mental health and/or substance use condition.

Peer Support

Peer support is a mutual form of shared interactions in which participants seek to use their personal experience to both help others and gain additional reinforcements for their own life circumstances. Peer support can occur in both individual and group settings. Usually, participants are not paid to participate in this process.

Peer Support Services

For the purpose of this report, the term "peer support services" is used to describe the **intentional** peer services that are delivered by people who have received training and certification to provide these services. They draw on their lived experiences in mental health, substance use, or co-occurring substance use problems. Their services

are reimbursable through Medicaid or other payers, or they are employed to provide these services. In some cases these services may also be provided by a volunteer who has achieved the requisite training and certification. This review focuses on those services provided by peers in mental health, substance use, and/or co-occurring mental and substance use service settings who have received the necessary training and certification. The term "*peer support specialist*" is used to describe the individuals who are trained and certified and deliver these services. The training, certification, and scope of services are further described in this report. Settings in which PSS are delivered include inpatient and outpatient facilities, day-treatment programs, and community settings (Salzer, Schwenk, and Brusilovskiy, 2010).

It is important to note the key distinction between mutual peer support and PSS. PSS are intentional services that are based on the lived experience, training, and certification of the provider and are designed to promote engagement, facilitate recovery, and support resiliency. In PSS, the relationship is not reciprocal, and the skill and degree of recovery is not the same between the provider and recipient (Davidson, Chinman, Sells, and Rowe, 2006).

Peer Specialist

Peer specialists, sometimes referred to as *peer support specialists*, *peer coaches*, or *peer support providers*, are individuals in recovery who provide PSS to individuals seeking to achieve and/or maintain their recovery from mental or substance use disorder (SUD) or co-occurring mental and SUD. For the purpose of this study, the term "*peer specialist*" is used to describe this role.

Medicaid defines a qualified *peer support provider* as a self-identified consumer who is in recovery from mental health or substance abuse conditions and assists others with their recovery. Minimal requirements for training and certification, supervision, and care coordination have been established (CMS, 2007). Additionally, a number of states have established state criteria that must be met for peer support providers to receive reimbursement for their services.

The Role of Peer Support Services in Health Care

Peer specialists are increasingly being deployed to help those with mental health, substance use, and co-occurring substance use conditions develop and maintain recovery-based goals and resiliency. In this role they can help prevent unnecessary acute hospital admissions, avoid preventable readmissions, and lessen over-utilization of ED facilities. The evidence base for these services is emerging, and different service models are expanding.

Interest and utilization of PSS has greatly increased since the 2007 letter to Medicaid directors approving Medicaid reimbursement for PSS. Recent estimates indicate that there are at least 335 peer support organizations in the United States

providing direct services (Lived Experience Research Network, 2013). Private insurers, the military health system, and the U.S. Department of Veterans Affairs (VA) have also expanded their interest in and use of PSS (Association for Behavioral Health and Wellness [ABHW], 2013; White House, 2012).

Eiken and Campbell (2008) have described three types of PSS for meeting the needs of individuals with behavioral health conditions:

- Peers providing distinct services to support problem-solving and self-management strategies.

- Peers with lived experiences of behavioral health conditions serving as part of a treatment team.

- Persons with the lived experience providing services that may be other than peer support that are informed by and based in part on personal recovery experiences.

Salzer et al. (2010) conducted a national survey of peer specialists to assess their principal roles and activities. Respondents from 28 states described an average work week of about 75 percent full-time equivalency. The racial and ethnic representation from this review included 79 percent self-identified as White, 12 percent as Black/African American, and 3 percent as Latino. The majority (66 percent) were female. The most common work environments included independent peer support program (24 percent); case management (19 percent); partial hospitalization, day program, inpatient or crisis center (10 percent); vocational rehabilitation or clubhouse (8 percent); and drop-in center (7 percent). Peer support services reported as most common included peer support; encouragement of self-determination and personal responsibility; support for health and wellness; addressing hopelessness and stigma; communication with providers; illness management; and friendship and leisure activities. Less frequent activities included support services for spirituality and religion; parenting; and dating.

Chinman and colleagues (2006) examined how consumer providers address patient and treatment system factors that contribute to poor health outcomes. As described below (see Figure 1), consumer providers of PSS are able to address unmet needs within clinical systems of care.

FIGURE 1. Peer Services Providers Address Unmet Patient and Clinical Service System Factors					
How Consumer Provider Services Address Patient and Treatment System Factors					
Factors that contribute to poor outcomes for those with SMI					
Patient Factors			Treatment System Factors		
Social isolation	Disconnection with ongoing outpatient treatment	Powerless & demoralization regarding illness	Overburdened providers	Fragmented services	Lack emphasis on recovery-rehabilitation, empowerment
Consumer provider services address each of the factors:					
↓	↓	↓	↓	↓	↓
Enhance social networks by: - role modeling - facilitating peer support activities	Engages patients; makes treatment more relevant through collaboration	Activates patients; teach coping & street smarts; provide hope through role modeling	Supplement existing treatment; increase access	Provide case management/ system navigation to increase access	Emphasize recovery: - liaison between consumer & system - advocate for community integration over symptom stabilization

The American Mental Health Counselors Association (ACMHA) Peer Services Toolkit (Hendry, Hill, and Rosenthal, 2014) reviews the range of roles and services provided by peer providers and how this workforce applies the principles of peer support in their work. The toolkit states:

> "Before, during and beyond crisis points they (PSs) provide compassionate listening, and a positive vision of the future. Additionally peer providers can work with individuals in goal setting, and developing achievable action plans. They can play an important role in supporting people in self-managing and working towards whole health goals, and they are uniquely qualified to assist peers in connecting with their communities, building supportive relationships, accessing formal and informal resources, and working with cultural humility to support people across a wide range of cultural differences."

These functions are important across the full continuum of health services.

Peer Support Services as Part of the Larger Health Care Service Systems

Reimbursement for Peer Support Services

A major step in the evolution of PSS occurred in 2007 when Medicaid designated them as evidence-based and reimbursable by states that include them in their state plans (CMS, 2007; Daniels, Cate, Bergeson, Forquer, Niewenhous, and Epps, 2013).

Currently more than 30 states are actively providing reimbursement for these services (Kaufman, Brooks, Bellinger, Steinley-Bumgarner, and Stevens Manser, 2014). The health home option established under the ACA in 2010 provides guidance on the core clinical features of organizations that provide PSS and the clinical service requirements for PSS (SAMHSA-HRSA 2012). In addition, the President's Executive Order (White House, 2012) has called for the training of 800 new peer specialists to serve the VA health systems.

In addition to the growing number of states that now allow Medicaid reimbursement for PSS, a substantial portion of PSS is reimbursed through state grants and contracts, federal grants, and service contracts with managed care organizations. Historically, these non-Medicaid funding sources have paid for peer specialists' involvement in services and programs such as psychiatric rehabilitation; drop-in centers; employment services; housing services; crisis and respite services; and young adult transition services (Hendry et al., 2014). Indeed, some of the pioneers of PSS are thriving in states where services are not Medicaid reimbursable and have always relied on non-Medicaid funding for reimbursement (e.g., California and New York).

A recent survey of peer support organizations providing direct services in the United States found that 77 percent of their funding come from governmental sources, with 33 percent reporting they receive federal funding, 8 percent are reimbursed by Medicaid, 61 percent receive state funding, and 45 percent receive funding from county/local governments (Lived Experience Research Network, 2013).

ABHW is an association representing the major behavioral health care management companies. ABHW notes that in specialty behavioral health care organizations, the use of PSS is most prevalent in Medicaid and other public sector care (ABHW, 2013). A variety of types of PSS are offered by ABHW member companies and include peer bridgers, whole health peer coaches, addiction recovery coaches, family peer navigators, family peer coaches, peer warm lines, and other community support programs. Core challenges noted for specialty behavioral health care organizations in developing these programs include the variable training and certification of peer specialists, the unstructured definitions of service types, and the capacity of peer service organizations to meet billing requirements. These organizations also struggle with their claims payment systems' capacity to adjudicate new PSS service codes.

ABHW has also identified a lack of national standards for PSS as a significant barrier to expanding their use in specialty behavioral health care organizations. ABHW notes that it is hard to assess core competencies among peer specialists, and national credentialing standards are difficult to establish due to variations across states. ABHW also identifies consistent billing and reimbursement policies as an impediment to broader use of this workforce (ABHW, 2013).

Coverage of Peer Support Services

Coverage for PSS has varied across different payer types. Medicaid has recognized PSS as a reimbursable service under state plans. Common billing codes used to bill for these services include Healthcare Common Procedure Coding System codes for peer services (H0038), psychiatric rehabilitation (H2017), community support (H2015), and Assertive Community Treatment (ACT) (H0039). Reimbursement is generally provided in 15-minute increments of service. Many states are building these services into their standard Medicaid coverage. However, they have not been included in the essential benefits that have been established for health exchange plans under the ACA. Nor are they generally included in the certificate of coverage for most commercial plans. Some specialty behavioral health care organizations have elected to cover these services as administrative costs for these plans.

To standardize the coverage of PSS in Medicaid, Medicare, and commercial plans, a set of level of care criteria for these services has been developed (Daniels et al., 2013). Standard practices for health insurers include the use of medical necessity and level of care criteria for determining the needed services at the appropriate level of intensity. These are evidence-based criteria that guide decision-making for necessity and payment.

Optum has developed four sets of level of care guidelines that address peer-to-peer services, peer bridger services, family-to-family support services, and family navigator services (Daniels et al., 2013). Through the establishment of these criteria it is possible to standardize the review of services and ensure they meet quality guidelines. Other specialty behavioral health care organizations have also developed level of care guidelines that are used in specific coverage contracts.

When contracting for peer-run services, managed care organizations consider three key factors: (1) ensuring high quality of services that are compliant with state and federal requirements; (2) ensuring services achieve positive, measurable results; and (3) supporting the principle of health care affordability, which calls for a cost-effective approach to services (Hendry et al., 2014).

Peer Support Services as an Evidence-Based Service

While the prevalence and availability of PSS continues to expand, the research literature yields few experimental trials of their effectiveness (Repper and Carter, 2011). This is due in part to the varying definitions of PSS (O'Hagan, Cyr, McKee, and Priest, 2010); a lack of established measures; variable range of training and certification of the workforce; unstructured service and intervention models; a lack of established outcome measures; and the lack of a uniform model or typology of peer-delivered services (Rogers, Kash-MacDonald, and Brucker, 2009). Past research has focused primarily on peer-delivered services as both individualized services models and team-based care approaches and not subjected to comparative analysis. Another limitation is that

evaluation designs have typically featured pre-post measures without clearly established control groups or longitudinal follow-up.

The research literature includes four systematic reviews of PSS (Simpson and House, 2002; Doughty and Tse, 2005; Rogers et al., 2009; Repper and Carter, 2011). The reviews in these reports are constrained by the lack of consistent outcome measures and the fact that there is no widely accepted model or typology of peer-delivered services (Rogers et al., 2009), although most of the studies focus on PSS in mental health rather than addictions.

The Simpson and House (2002) review of PSS studies found that these services led to greater levels of satisfaction with personal circumstances among those receiving services and a decrease in hospitalizations. They concluded that "users [of behavioral health services] can be involved as employees, trainers, or researchers without detrimental effect." Further, they found that "involving users with severe mental disorders in the delivery and evaluation of services is feasible."

Doughty and Tse (2005) concluded that the research on peer-delivered services yielded positive outcomes for clients. They note that the research is limited by the settings in which services are delivered, and it is often difficult to differentiate outcomes between traditional and peer-delivered services.

In their review of the literature on PSS, Rogers et al. (2009) found that there were ten commonly used outcome measures to assess these services:

1. Quality of life
2. Recovery attitudes
3. Perceptions of empowerment
4. Self-confidence
5. Self-esteem
6. Hospitalization
7. Relapse
8. Psychiatric symptoms
9. Criminal justice involvement
10. Employment

They conclude that the results of research on peer services "remain equivocal." They note that there are promising results and that better research is needed to understand the unique contributions of peer services to the overall outcomes of care.

Repper and Carter (2011) reviewed studies that examined PSS for their effectiveness of peer support, benefits to consumers, empowerment, social support and social functioning, empathy and acceptance, reducing stigma, and hope. They concluded that "although scarce in the literature, the few experimental trials show that at the very least, peer support workers (PSWs) do not make any difference to mental health outcomes of people using services. When a broader range of studies are taken

into account, the benefits of PSW become more apparent." They also examined the range of services provided by PSS and the impact of these on the recovery process. They found that "what PSWs appear to be able to do more successfully than professionally qualified staff is promote hope and belief in the possibility of recovery, empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks. It is just these outcomes that people with lived experience have associated with their own recovery; indeed these have been proposed as the central tenets of recovery: hope, control/agency and opportunity." Indeed, many argue that these tenets are the most significant driving factor of PSS. Measurement of these factors is among the most common outcomes reported in the published literature. It could be argued that increasing hope, control/agency, and opportunity are the underlying mechanisms for clients' overall health.

Limited Research Findings

Despite the methodological challenges, there are significant examples of how innovative models of PSS are being used to help reduce inpatient admissions, limit readmissions, and control unnecessary ED utilization. A recent evidence-based review of PSS (Chinman et al., 2014) found that "[t]he level of evidence for each type of peer support service was moderate. Many studies had methodological shortcomings, and outcome measures varied. The effectiveness varied by service type. Across the range of methodological rigor, a majority of studies of two service types -- peers added and peers delivering curricula -- showed some improvement favoring peers. Compared with professional staff, peers were better able to reduce inpatient use and improve a range of recovery outcomes, although one study found a negative impact. Effectiveness of peers in existing clinical roles was mixed. PSS have demonstrated many notable outcomes. However, studies that better differentiate the contributions of the peer role and are conducted with greater specificity, consistency, and rigor would strengthen the evidence."

The evidence review by Chinman et al. (2014) summarizes the findings separately across each of the three methodological approaches that are directly relevant to the present study. These are randomized controlled trial (RCT) studies of PSS; quasi-experimental studies of PSS; and correlational or descriptive studies of PSS. An overview of the studies, interventions, outcomes measured, findings, and evidence rating review are described in Tables 1-3 below and inform the evidence base for the present study. Of note, since this evidence-based review was conducted on a set of inclusion criteria, some of the studies referenced in this report for the present study may not be included in this review.

TABLE 1. RCTs of PSS with Mental Health and Co-occurring Mental Health and Substance Abuse Service Recipients that have Measured Health Care Utilization Outcomes			
Study and Sample Description	Intervention	Outcomes Measured	Major Study Findings
Solomon & Draine, 1995 (Also see Solomon, Draine, & Delaney, 1995) N=96 individuals with SMI in community mental health center at risk for hospitalization	Participants assigned to case management team of peers vs. case management team of non-peers.	Therapeutic alliance, income, social network size, days hospitalized, psychiatric symptoms, attitudes toward medication compliance, quality of life, interpersonal contact, social functioning, treatment satisfaction.	There were no significant differences between treatment and control group on measured outcomes 2 years after initiation of services.
Clarke et al., 2000 N=163 adults with chronic SMI	Participants assigned to usual care vs. ACT non-peer vs. ACT with peers.	Percentage of participants hospitalized and number of days to hospitalization; time to first ED visit, arrest, homelessness.	Time to first hospitalization was earlier for ACT non-peer group than the ACT with the peer group. There were no significant differences between these groups for the first instance of homelessness, first arrest, or first ED visits. More participants in the ACT non-peer group had hospitalizations and ED visits than those in the ACT with peer group.
Sells et al., 2006 N=137 adults with SMI; 70% had co-occurring SUD	Participants assigned to ACT alone vs. ACT plus peer-delivered case management.	Therapeutic relationship, frequency and severity of substance use, utilization of various outpatient and day-treatment services, and treatment engagement.	Participants with peers reported better therapeutic relationship than controls at the 6-month follow-up. Those who were least engaged with peers had more provider contact than the control group. The therapeutic relationship at 6 months predicted treatment engagement and service utilization at 12 months, but there were no between-group differences.
Druss et al., 2010 N=80 individuals with SMI and chronic medical illness	Peers delivering curricula: HARP program versus usual care.	Patient activation, primary care visits, physical activity, medication adherence, and health-related quality of life	Participants in HARP had higher patient activation and higher rates of primary care visits 6 months after intervention than those with usual care. Medication adherence, physical health quality of life, and physical activity did not differ between groups.
Sledge et al., 2011 N=74 patients with major mental illness hospitalized 3 or more times in past 18 months	Participants assigned to usual care vs. peer mentor plus usual care.	Number of hospitalizations and hospital days	Participants with peers had significantly fewer admissions and fewer hospital days than those in usual care at the 9-month follow-up.
NOTES: Articles are listed in chronological order. Various threats to both internal and external validity were considered in each study's rating of "limited" (study had several methodological limitations) or "adequate" (study had few or minor methodological limitations). Multiple publications based on the same RCT are described in the same row.			

TABLE 2. Quasi-Experimental Studies of PSS Mental Health and Co-occurring Mental Health and Substance Abuse Service Recipients that have Measured Health Care Utilization Outcomes			
Study and Sample Description	Intervention	Outcomes Measured	Major Study Findings
Felton et al., 1995 N=104 participants with SMI	Case management teams vs. case management teams plus non-peer assistants vs. case management teams plus peer specialists.	Self-image and outlook, treatment engagement, social support, quality of life, life problems, housing instability, income, and family contact.	Clients on case management teams plus peer specialists reported gains in quality of life indicators, reductions in some major life problems, and more treatment engagement compared with those in the other two groups over the course of the 2-year study. There were no differences in outcomes between teams with non-peer assistants and those with standard care.
Klein et al., 1998 N=61 participants with co-occurring mental and SUD	Intensive case management teams with peers vs. case management teams without peers.	Crisis events (e.g., ED visits), number of hospital days, social functioning, use of community resources and social integration, and quality of life.	Participants with peers had fewer inpatient days, better social functioning, and some improvements in quality of life indicators at the end of the intervention.
Chinman et al., 2001 N=158 participants with SMI	PSS added to standard care vs. a matched control group in standard care.	Number of hospitalizations and hospital days.	There were no significant differences between groups in outcomes 6 months after the service start date.
Min et al., 2007 N=556 participants with SMI and SUD with history of hospitalization	Teams with case management vs. teams with case management plus peer worker.	Days to first hospitalization and percentage hospitalized over 3-year period.	Participants on teams with peers had more time in the community and less inpatient use.
Schmidt et al., 2008 N=142 participants with SMI and with a recent hospitalization	Case management team vs. case management team plus peer.	Client contact, percentage with crisis center visits, percentage hospitalized, number of hospitalizations and hospital days, outpatient mental health service utilization, medication use, substance abuse, and housing stability.	There were no significant differences between groups in outcomes measured at the 12-month follow-up.
van Vugt et al., 2012 N=530 participants with SMI in 20 ACT teams	ACT teams without peers vs. ACT teams with peers.	Level of functioning, met and unmet needs, working alliance, number of hospital days, and number of homeless days.	At 1-year and 2-year follow-ups, clients of teams with peers had better psychiatric and social functioning, improvements in met and unmet needs related to their personal recovery, and fewer homeless days than clients of teams without peers. Peer presence was associated with an increased number of hospital days.
NOTES: Articles are listed in chronological order. Various threats to both internal and external validity were considered in each study's rating of "limited" (study had several methodological limitations) or "adequate" (study had few or minor methodological limitations).			

TABLE 3. Correlational or Descriptive Studies of PSS Mental Health and Co-occurring Mental Health and Substance Abuse Service Recipients that have Measured Health Care Utilization Outcomes			
Study and Sample Description	Intervention	Outcomes Measured	Major Study Findings
Chinman et al., 2000 N=1,203 homeless participants with SMI	Participants with homeless outreach teams alone vs. those with homeless outreach teams with peers.	Quality of life, homelessness days, social support, symptoms and mental health problems, alcohol and drug problems, and days worked.	There were no significant differences between groups on outcomes over a 12-month period.
Landers et al., 2011 N=35,668 participants with a reimbursed community mental health service	Participants without a PSS claim in past year vs. those with a PSS claim in past year.	Percentage with a hospitalization or crisis stabilization.	Compared with participants without peers, more participants with peers used crisis services, but fewer had a hospitalization.
NOTES: Articles are listed in chronological order. Various threats to both internal and external validity were considered in each study's rating of "limited" (study had several methodological limitations) or "adequate" (study had few or minor methodological limitations).			

State-Level Training and Certification for Peer Specialists

As of 2014, 37 states have established training and certification program for PSS (Kaufman et al., 2014). There is a wide variation of training and certification standards. A range of educational models have been used by the organizations that train this workforce. Some principal training programs include Depression and Bipolar Support Alliance (DBSA), International Association of Peer Specialists (iNAPS), Recovery Innovations (RI), and Appalachian Consulting Group (ACG). The DBSA program has been used to train and certify almost 500 new peer specialists for the VA health system. Certification is generally established at the state level, is testing based, and administered by national training organizations, local academic institutions, and others.

The ACMHA Peer Services Toolkit (Hendry et al., 2014) identifies a core set of individual qualities required for the peer specialist workforce. These include the following: person has progressed in his/her own recovery or has 1 year of addiction recovery and is actively involved in recovery activities; willingness to self-identify; willingness to share knowledge and experience of recovery; exhibits signs of a spiritual awakening; can act as a role model; listens and learns from people served; creates environments that promote recovery; works in partnership with the individual; promotes trauma-informed care (e.g., asking "what happened," not "what's wrong"); helps to navigate the system; helps individuals to examine personal goals and define in achievable ways; motivates change desired by the individual; and may act as liaison or proxy for the individual if desired.

An analysis of the survey findings of Kaufman et al. (2014) provides a comparison of the types of training and certification programs offered by different states. It is important to note that not all states are included in this survey, as some states have yet to develop formal training and certification programs. This does not mean that those states are lacking in PSS programs, and findings from the informant interviews suggest that some of the states without established requirements still have robust and model programs (examples include New York and California).

As of 2014, there is a range of different certification, training, and billing arrangements adopted by the states (Kaufman, 2014). As an example, characteristics of state requirements for PSS and the workforce that delivers them include the following:

- Thirty-seven states have implemented statewide uniform PSS certification programs, and seven states are actively developing them.

- In 19 states there is a state agency that is the program administrator or credentialing agency, and in six states this is provided by a combined state and external organization.

- Sixteen states require up to 40 hours of training, 12 states require between 41 and 80 hours, and three states require more than 80 hours.

- Thirty-five states have established requirements for the completion of a certification exam.

- Twenty-nine states have reported that they have requirements for continuing education for recertification, and six states do not. Of those states reporting continuing education requirements, six have no requirements, seven require between 10 and 20 hours, and 14 require between 21 and 40 hours. Ten states did not list requirements. In general, states that require continuing education do so on a 2-year cycle.

- Thirty of the states that have implemented a standard training and certification program for PSS also have Medicaid billable services.

- Fifteen states cover the training costs for PSS, and an additional four share the cost.

- Five competency areas are reported as common in the training programs for PSS. These include advocacy (15 states); professional responsibility (18 states); mentoring (11 states); recovery support (24 states); and cultural competency (13 states). Twelve states did not report cultural competency information.

The ACMHA Peer Services Toolkit (Hendry et al., 2014) cites 21 common elements in peer specialist training programs. These are as follows:

1. The history of the peer movement;
2. Insight into personal recovery;
3. Five stages of recovery;
4. Role of peer support;
5. Creating program environments that promote recovery;
6. Stages of change/the dynamics of change;
7. Effective goal setting that promotes successful change;
8. Facilitating support groups that promote recovery;

9. Effective listening;
10. Motivational interviewing;
11. Facing one's fears;
12. Combatting negative self talk;
13. Problem-solving with individuals;
14. Peer specialist ethics and boundaries;
15. Power, conflict and integrity in the workplace;
16. Creating the life one wants;
17. Wellness recovery action plans (WRAP);
18. Understanding the impact of trauma;
19. Working towards shared responsibility;
20. Looking at crisis as an opportunity; and
21. Personal sharing and disclosure.

Cultural diversity and competency are also described as cross-cutting themes in many of these areas.

Peer Support Services and Health Care Utilization and Outcomes

The focus of this study is to investigate PSS that address the needs of individuals with mental health, substance use, or co-occurring mental and substance use conditions. As background for this study, a series of discussions was conducted with key informants who were identified as leading experts in the field (a complete list is included in Appendix A). The study typology of services outlined earlier in the report, including crisis and respite services, transitions in levels of care, and community-based services to promote recovery and resiliency, was used as a framework to discuss key activities for PSS and how these services help reduce unnecessary inpatient admissions and readmissions and utilization of emergency services. An overview of findings is presented in Figure 2 below.

In addition to the variables identified through our key informant interviews that impact ED and hospitalization utilization, there are a number of additional outcomes that could be considered. These outcomes will be determined, in part by the sites. For example, the ACMHA Peer Services Toolkit (Hendry et al., 2014) identifies a range of useful measurements to assess the successful individual-level outcomes of peer services. These include the following:

- Personal Outcome Measures (Council on Quality and Leadership, 2012).

- Recovery-Oriented Systems Indicators (ROSI) (Dumont, Ridgway, Onken, Dornan, & Ralph, 2005).

- Community integration and measuring participation (Salzer and Baron, 2006).

- Community Participation as a Predictor of Recovery-Oriented Outcomes Among Emerging and Mature Adults with Mental Illness (Kaplan, Salzer, and Brusilovskiy, 2012).

FIGURE 2. Overview of the Impact of PSS on Hospitalization and ED Utilization				
Study Typology of PSS	**Definition**	**How They Impact Hospitalization/ ED Rates**	**Key Factors in PSS That Mediate Outcomes**	**Desired Outcomes**
Crisis and respite services	→ Programs and services that provide an acute response to individuals who are experiencing a psychiatric emergency and need an urgent response.	→ Provides alternatives to hospitalization and ED use. Fosters stability and community tenure.	Peers are employed to provide services. Training and certification standards exist. Services are reimbursable. Services are covered under Medicaid state plans. Peer specialists are integrated into the health care system. Community has other supportive resources and services to support clients. Peers are part of health care team and provide input into medical records. Track record of success in the community. Supported by other providers. Peers focus on whole health.	Reduction in ED, hospitalization, and inpatient use. Meeting PSS program-specific goals.
Transition in levels of care	→ Programs and services designed to provide assistance and support to individuals who are involved in changes to their treatment services that involve new providers or settings and levels of acuity.	→ Helps reduce/ prevent crisis, crisis relapse, hospital readmission, ED use.		
Community-based services to promote recovery and resiliency	→ Programs and services designed to provide ongoing engagement, support, and activation for those who have successfully established recovery and illness management plans.	→ Keeps individuals healthy in the community and helps prevent hospitalization.		

Systems-level outcomes cited include the following:

- Re-hospitalization rates compared to individuals not receiving peer support;
- Changes in engagement rates for people in traditional services;
- Number of outpatient services accessed;
- Overall satisfaction with services;
- Length of time people remain in traditional services; and
- Improvement in quality of life and other wellness measures.

A Proposed Typology of Peer Support Services for the Reduction of Preventable Hospitalizations and Emergency Department Utilization

The focus of this study is to investigate and better understand how PSS address the needs of individuals with mental health or co-occurring mental and substance use conditions, and how these services help mitigate unnecessary psychiatric inpatient and ED use. While the principal funding support for PSS has historically occurred in publicly funded health systems, this study seeks to better understand the applicability across all payer systems. To better define this scope of services, we propose the following model, or typology, as displayed in Table 4.

TABLE 4. PSS Models of Care that are Likely to Impact Hospitalization and Health Care Costs	
PSS Categories	**Definitions**
Crisis and respite services	These are programs and services that provide an acute response to individuals who are experiencing a psychiatric emergency and need an urgent response with the goal of fostering stability, thus reducing the need and use of psychiatric hospitalization or ED use, and supporting community tenure.
Transition in levels of care	These programs and services are designed to provide assistance and support to individuals who are involved in changes in their treatment services that involve a shift from 1 provider or setting to another, as well as levels of the acuity of care.
Community-based to promote recovery and resiliency	These programs are designed to provide ongoing engagement, support, and activation for those who are establishing and building community tenure, and who are in the process of recovery and illness management.

The programs across these categories may share common acute and routine services and recovery goals. While most PSS programs will be able to classify their program into one of these three categories, some may deliver a more comprehensive array that cuts across all three categories. For the current study, and from a health care systems perspective, we adopt this typology to highlight program characteristics, service models, and outcomes measures that are relevant to health care costs and specifically hospital admission and readmission rates.

Crisis Services and Alternatives to Acute Hospitalization

Overview

Being admitted to psychiatric hospital-based care is expensive and disruptive to both individuals with behavioral health conditions and their families. Having repeated admissions to psychiatric hospital care is a common and substantial problem. Preventing psychiatric readmissions requires the provision of short-term alternatives for individuals who are "not at significant risk of harm to self or others and ongoing community-based treatment services and supports" (Gaynes et al., 2015). Research on the challenges of psychiatric readmissions focuses on three levels of intervention: short-

term alternatives to re-hospitalization; transition support services; and long-term approaches for reducing the needs for re-hospitalization (Gaynes et al., 2015).

Peer support specialists have actively worked to develop, operate, and provide services in a range of programs that provide alternatives to psychiatric hospitalization. Crisis respite programs provide a safe and homelike environment to support people through an episode of crisis (Ostrow and Fisher, 2011). Common principles include an environment that is safe and establishes acceptance through connections; hope is held by others when one may not be able to hold it for himself/herself; everyday language is used to describe experiences; self-care and personal responsibilities are a central focus; and gaining a sense of mastery and power over one's life is encouraged (Ostrow and Fisher, 2011). The goal of peer-run crisis respite is to encourage less dependence on formal mental health systems of care and the associated trauma that commonly occurs in EDs and inpatient psychiatric EDs. By bolstering an individual's stability in a time of crisis, it is possible to support resiliency and prevent unnecessary ED visits and hospital admissions.

One randomized controlled study of crisis respite care found that the average rate of symptom improvement was greater in this alternate care than in the hospital comparison. Recipients of care in these settings also demonstrated greater satisfaction. The average savings for respite care was more than $450 per day (Greenfield, Stoneking, Humphreys, Sundby, and Bond, 2008).

Respite care programs provide a spectrum of services and can accommodate a range of participants. A review of innovations in respite programs (Ostrow and Fisher, 2011) cites 12 examples in the United States. These programs have federal, state, and county grant funding and serve between two and eight people in their residential services at any given time. Their average length of stay is between 1 and 14 days. Many programs also include other services such as warm line crisis services, drop-in accommodations, and rehabilitation services such as housing and vocational care.

In Pierce County, Washington, the Regional Support Network (RSN) has helped develop a "living room crisis model." This approach is more welcoming than a traditional ED setting, and services are provided by both a peer support staff and consulting clinicians. This program has contributed to a reduction in admissions for psychiatric care of 32.3 percent and reduced readmissions of 26.5 percent over 3 years. It has also reduced the average number of inpatient days per thousand from 19.6 in 2009 to 13.7 in 2013 (Optum, 2014a).

A peer-run respite care program has also been developed by Project Hope Peer Support Network in Long Beach, California. The Hacienda of Hope is designed to provide crisis support services 24 hours/day, 7 days/week for those who do not require immediate on-site medical treatment (Project Return Peer Support Network, 2014). Most people who engage in this program stay for 1-3 days, and there is a maximum stay of 14 days. WRAP and the Eight Dimensions of Wellness programs are provided by the peer staff.

Peer Programs to Support Level of Care Transitions

Transitions between inpatient and outpatient levels of care can be difficult and require both careful care planning and ongoing support for an individual's re-integration into community settings. A number of service models have been developed to support these level of care transitions and are sometimes described as peer bridger programs. Arguably, the first such program was developed in 1994 when the New York Office of Mental Health (OMH) approved a pilot program for the New York Association for Psychiatric Rehabilitation Services (NYAPRS) to assist individuals with long or repeated psychiatric hospital stays make successful transitions to their home communities (http://www.NYAPRS.org). The primary role of the NYAPRS peer bridger program is to help individuals who are admitted to facility-based psychiatric care establish a trusting and engaged relationship that provides them a peer role model, mentor, teacher, advocate, and ally to facilitate successful transition to their home communities and promote long-term tenure.

The NYAPRS peer bridger program offers a training curriculum that focuses on four key components, which are outreach and engagement, crisis stabilization, wellness and self-management skills, and community support. Initial data from this program demonstrated that for individuals served in 1998, there was a 71 percent reduction in re-hospitalization. Recent data supports continued positive outcomes for this program and increased contracting with managed care organizations for these services (Hendry et al., 2014).

Other consumer-led organizations are also actively developing and providing level of care and peer bridger transition services. However, these interventions are often not a fully structured or manualized service model. Therefore, there is no way to ensure the fidelity of program designs being implemented across different programs, the training requirements and core competencies of their peer providers, or the outcomes measured, if any.

A peer navigation model of intervention called The Bridge was tested against a treatment as usual group in a randomized trial (Kelly, Fulginiti, Pahwa, Tallen, Duan, and Brekke, 2013). The Bridge model of intervention is described as a comprehensive engagement and self-management model whereby participants are taught to access and manage their health care effectively. It is a manualized approach with four components: assessment and planning, coordinated linkages, consumer education, and cognitive-behavioral strategies to support health care utilization behavior change and maintenance. Findings of the study supported changes in seeking care from a primary care provider rather than the ED, and reduced physical health symptoms.

Optum has been a leader among managed behavioral health care organizations in the deployment and reporting of outcomes for their PSS programs. In Wisconsin and New York, Optum reports utilizing a peer bridger-based service model that supports

community re-engagement after hospitalization. The Wisconsin program was delivered by the Grassroots Empowerment Project (GEP), a peer-run organization, and in New York the program was run by NYAPRS. Findings from this Optum program include reductions by 30 percent in inpatient days utilized and health costs savings of 24 percent in Wisconsin and New York. In New York, these programs resulted in a reduction of inpatient days by 63 percent and overall behavioral cost savings to the plan of 47 percent (Optum, 2014b). It is difficult to assess this self-report data, and it is also not clear if there is fidelity between the GEP and NYAPRS peer bridger programs. A rigorous evaluation of this type of program would require a structured evaluation of the components and outcome measures, and that was not done in this case.

Community-Based Peer Support Services Programs to Promote Recovery Supports

A number of community-based service programs have been developed that deploy peer specialists to deliver PSS in a variety of roles. Some are led by national organizations or by community-based consumer-run organizations, and others are built into formal clinical service systems. The goals of these services include ongoing community-based support for recovery, improved community engagement and tenure, and sustained resiliency.

Some of the major national organizations include the following:

- Mental Health America (http://www.mentalhealthamerica.net) provides a range of advocacy, screening and prevention, and community-based service supports. These are based on more than 100 years of service and offer a range of national community-based peer support programs.

- DBSA (http://www.dbsalliance.org) offers both training and certification for peer support specialists and a national network of peer support groups and other wellness resources. DBSA recognizes an approach that says, "We've been there, we can help."

- The National Alliance on Mental Illness (http://www.nami.org) offers programs for families and individuals that include screening, educational resources, advocacy, and community-based programs.

- RI (http://www.recoveryinnovations.org) has developed a nationally recognized peer support specialist training program that is designed around the principles of hope, empowerment, wellness, personal responsibility, a community focus, and connectedness.

The SAMHSA-HRSA Center for Integrated Health Solutions has also developed a manualized PSS training program that supports the integration of both physical and behavioral health. Whole Health Action Management (WHAM) is a structured program

that includes both advanced training for peer support specialists and a workbook for improved health management.

Community-based recovery support programs target a range of goals and promote services to foster resiliency and promote community tenure. This range of services focuses on an individual's need for housing, employment, and other psycho-social resources. Outcomes for these community-based services are generally service type and are program-specific. For example, the ACMHA Peer Services Toolkit (Hendry et al., 2014) reports that "Mental Health Peer Connection's Life Coaches helped 53 percent of individuals with employment goals to successfully return to work in the Buffalo, NY area, 2010 program evaluation data; Western NY's Housing Options Made Easy helped 70 percent of residents to successfully stay out of hospital in the following year, 2011 program evaluation data."

Conclusions -- Environmental Scan

An emerging evidence base has been developed that supports the findings that PSS can be effective in promoting recovery-based outcomes for those with behavioral health conditions. There are a number of inherent challenges for evaluating the impact of these services on health outcomes. These include the different training and certification standards for providers across states, varying levels of coverage and reimbursement for these services, and a lack of a consistent service models. However, both the research literature reviewed and discussions with key leaders in the field support the evolving role of this workforce.

There has been a less specific research focus on how these services are able to affect the health outcomes of inpatient hospital and ED utilization. For the purpose of this study, a three-tiered typology of services has been developed to specifically assess the different models of care. These services include crisis/respite care, level of care transitions, and ongoing community-based recovery supports.

The site visit protocols and site selection will be influenced by the findings of this environmental scan.

2. SITE SELECTION

A comprehensive environmental scan was completed to address the questions of this study (see Chapter 1). The environmental scan focused on core topics, including:

- The expanding role of PSS as a part of the behavioral health care delivery system.

- PSS and its impact on avoidable psychiatric hospitalization, readmissions, and ED utilization among those with behavioral health conditions.

- The impact of PSS on general health care utilization and other health outcomes.

- The evidence base for peer-delivered services.

A national panel of experts were convened to advise this study (see Appendix A for a list of panel members). In conjunction with this group and through federal input and other key informants (see Appendix B), about 15 exemplary PSS programs were identified to help address the research questions. Telephonic case reviews were conducted with eight programs. Summaries of these case reports are included in Appendix C. From this list and in conjunction with the Federal Project Officer, four programs were selected for in-person site visits to further explore in-depth how these PSS programs impact unnecessary hospitalizations and readmissions, as well as ED utilization.

Two members of the study team conducted one-day site visits to each of the four selected PSS programs. Agendas were developed in collaboration with the PSS programs. The site visit included scheduled times with the PSS workforce, leadership, PSS programs, and, in some cases, funders. Detailed case studies are provided based on the information collected during the site visit. The four site visits provide a strong foundation for the three-level peer services framework developed. Outcomes of the programs are also discussed and opportunities for further study are reviewed as part of this report.

Case Study -- Selection Process

Based on the recommendations of an expert panel, federal input, and other key stakeholders, about 15 national programs were recommended for review. Eleven PSS programs that fit within this three-level framework were considered for preliminary review. Three of the programs nominated for phone interview/case study were not included based on unresponsiveness or because they were not found suitable for the study. The participating programs are included in Table 5. Overview summaries of these programs are included in Appendix C.

TABLE 5. Participating Site Visit Programs		
Organization	**Program(s)**	**State**
Baltic Street, AEH, Inc.	Bridger	New York
Georgia Mental Health Consumer Network, Inc. (GMHCN)	Peer Support, Wellness, and Respite Centers	Georgia
Housing Options Made Easy, Inc.	Southern Tier Recovery Activities Without Walls (STRAWW), Supported Housing	New York
Mental Health Association of Southeast Pennsylvania (MHASP)	Peer Support Teams, Recovery & Education Centers, Self-Directed Care	Pennsylvania
New York Association of Psychiatric Rehabilitation Services, Inc. (NYAPRS)	Peer Bridger	New York
Optum Behavioral Health	Pierce County RSN	Washington
Projects to Empower and Organize the Psychiatrically Labeled (PEOPLe, Inc.)	Rose House	New York
Recovery Innovations (RI) Arizona	Living Room, Peer Recovery Team, Peer Advocacy Services, Community Advocacy, WELL, WRAP, Circle of Friends	Arizona

One-hour phone-based discussions were conducted with each of the nominated programs. Semi-structured interview formats were used and each of the review areas included a series of open-ended questions. Two interviewers participated in each review. The topics covered in these reviews included:

1. The description of the peer services program model, and the extent to which it is a replicable model and can support consistency within the program and comparison across other programs.

2. The financing of the peer services program and the mechanisms that support the reimbursement of services and employment of peer specialists.

3. The data and measurement of outcomes that are conducted by the program sites, and the extent to which these inform services and help improve quality of programs.

4. The training and certification of the peer services workforce, and the extent to which these are mandated by state or program-established requirements.

Based upon the findings of the eight telephonic program reviews, four PSS programs were identified for site visits to examine their impact on the three research questions. These research questions were:

1. What models or methods of practice demonstrate the most promise toward reducing preventable psychiatric hospitalization, re-hospitalization, and ED use?

2. To what extent are these models being utilized, and at what level of the system (e.g., states, counties, cities, organizational networks)?

3. What are the structural supports for these innovative practices -- including funding, training, and credentialing requirements -- offered through or outside the behavioral health care system?

The phone-based case studies (see Appendix C) illustrate the key components of the PSS programs recommended for this study. Each of the programs reviewed has unique and contributory elements. The study design of four site visits required the selection of targeted programs. A number of factors were used to help identify the target sites for this study. These include:

- Diversity of program design based upon the three levels of PSS identified in the study.

- Program components and replicability of service model.

- Geographic diversity.

- Availability of data relative to hospitalization, re-hospitalization, ED diversion, and other outcome and quality data.

- Payer sources and types for the programs identified.

- Other characteristics unique to each of the programs.

Four programs were selected for the site visits: Georgia Mental Health Consumer Network (GMHCN); New York Association of Psychiatric Rehabilitation Services; Optum Pierce County, Washington; and RI (Arizona). Summaries of the site visit case studies are included in Chapter 3.

3. FOUR SITE VISIT CASE STUDIES

This section contains four site visit case study reports. These case studies are meant to provide a brief description of the four PSS programs reviewed in this study. The case studies highlight program-specific information corresponding with key study questions. They are intentionally uniform in their headings and sections; provide summary level information; and are not meant to exhaustively include the information gathered during the site visit.

Each of the case studies includes a table of a service framework that was developed for this study. The table lists three categories of PSS that are likely to impact preventable hospitalizations, readmissions, and ED utilization. The table also highlights the service programs offered by each of the organizations within the three categories. Additionally, each of the organizations participating in the site visits had the opportunity to review the case summaries and correct any inaccuracies.

GEORGIA MENTAL HEALTH CONSUMER NETWORK, INC.

Program Background

The GMHCN is a non-profit corporation founded in 1991 by Georgia consumers of mental health, developmental disabilities, and addictive disease services. The GMHCN PSS program was initiated through consumer grass root efforts and collaboration with state leaders. The GMHCN's strong relationship with state leadership helped make Georgia the first state to authorize Medicaid reimbursement for PSS. GMHCN continues to work with the state to foster a recovery oriented framework for services, including collaboratively drafting of state service definitions. The PSS programs offered by GMHCN are embedded within the larger Georgia provider network in which peers are employed. There are over 1,200 certified peer specialists in Georgia, and training and certification of the workforce is coordinated through GMHCN.

> *"In our state, funding for PSS has been available for 16 years. The Georgia Consumer Network and the Certified Peer Specialist Program is the crowning achievement of the Georgia Mental Health System."*
>
> *-- Georgia Department of Behavioral Health and Developmental Disabilities staff*

GEORGIA MENTAL HEALTH CONSUMER NETWORK PROGRAMS THAT IMPACT HOSPITALIZATION AND ED USE	
PSS Categories	**GMHCN Programs**
Crisis and Respite Services	• PSWCs
Transition in Levels of Care	• Peer Mentors Program
Community-Based to Promote Recovery and Resiliency	• 24-hour Crisis Phone Lines • Daily Structured Education Programs

Service Catchment Area

Services are primarily focused in the cities of Decatur; Cleveland; Cartersville; Moultrie; and McDonough.

Peer Support Services Model

The GMHCN uses a hybrid model of services that draws from the Intentional Peer Support (IPS) model to guide PSS programs (http://www.intentionalpeersupport.org/what-is-ips/) and other mutual support principles. They also use the WHAM program to support integrated health goals and services. The training manual for certifying Peer Support Specialists was developed by the ACG.

Service Recipients

Individuals must be at least 18 years of age and self-identify as a person in recovery from mental health challenges. All individuals are self-referred and are welcome, regardless of insurance status. No financial or insurance information is requested from service recipients.

> *"The only wrong place for a certified peer specialist is no place."*
>
> *-- Sherry Jenkins Tucker, GMHCN Director*

Training and Certification of Peers

GMHCN provides Certified Peer Specialist training for consumer peers within Georgia. The Certified Peer Specialist training curriculum was developed by the ACG. The training registration fee is $85 per-person, although it can be waived, as needed. The training is manualized. The GMHCN provides approximately five trainings per year. GMHCN reports great demand for the trainings, with 100-300 applicants for each training session. Training sessions can accommodate up to 45 consumers. The initial training lasts 9 days. Twelve hours of Continuing Education Credits are required annually to retain certification.

Advanced training for peers who have completed the Certified Peer Specialists Training are also offered through GMHCN and include WHAM, Mental Health First Aid, and peer services for working with prison/forensic populations, older adults, and homeless populations.

Financing Services

Many GMHCN peer programs are in partnership with, and funded through, service contracts with the Georgia Department of Behavioral Health and Developmental Disabilities. Unlike many other PSS providers within Georgia, GMHCN does not bill Medicaid directly. Instead, GMHCN submits monthly reports to the state that are used to monitor contract compliance. Reimbursement for services is paid by the state retrospectively, after processing the GMHCN monthly report. There are no per-person costs that are billed to any payer. Peer specialists do not contribute to medical records or bill for their activities or time with service recipients. Peer specialists do document their interaction with consumer clients, but these records are primarily used for supervision purposes and contribute to the GMHCN monthly report to the state. The monthly report to the state requires that certain deliverables are met. Example deliverables include: an average number of two respite beds are filled per day; an average of ten calls are received at the call center per day; and an average of five participants participate in daily programming. GMHCN follows compliance regulations (Health Insurance Portability and Accountability Act [HIPAA] and CFR-42) as part of their state contract.

Featured Programs

Peer Support Wellness Centers

The GMHCN operates five Peer Support Wellness Centers across the State of Georgia. The role of these Centers is to provide support before a crisis occurs or as someone is adjusting after a mental health crisis. The GMHCN describes their services as "preventative" (of hospitalization or ED use). Individuals who participate in the Center programs are self- referred. Individuals are encouraged to engage in Center services when they feel as if they might be getting close to a crisis or feel they need a safe place that is an alternative to hospitalization. Individuals are welcome to walk out and leave whenever they want.

The Centers each have three beds -- two beds that are set aside for first time visitors and one bed that is set aside for "an old friend." An old friend is someone who has had a prior stay at the Center and would like to return for a short-term stay. Center staff report that there is a consistently high demand for the "old friend" beds, and there is often a waiting list. The center is staffed 24 hours per day by a peer specialist. Staff report that individuals rarely need to be transported form the Center to the hospital.

Funding for the Centers is provided by the state and requirements include that each crisis center fill a minimum of two respite rooms each night. As part of the contractual requirements with the state, centers provide encounter and consumer self-report information.

All of the wellness centers provide open access to computers, educational programing, and other resources to promote wellness and recovery.

Wellness Activities

Wellness activities and classes are offered at each of the five Peer Support Wellness Centers. The scheduled activities and classes are offered daily and are open to individuals who are in residence at the Centers and mental health consumers living in the community. There are generally three Wellness Activities offered daily. Wellness

activities cover topics such as WRAP, housing, financing and budget assistance, and vocational and educational help.

Warm Line

The GMHCN provides a 24/7 "warm line." The call center for this service is housed within each of the five Peer Support Wellness Centers, and staffed by on-site peer specialists. Peer specialists who are employed to provide this service receive additional training and use a training manual that guides the services provided by this program. Inbound calls generally last no more than 20 minutes. Crisis calls that are more acute than the warm line can accommodate are rerouted to a statewide crisis line that is staffed by traditional service providers. Callers to the warm line cannot request specific staff, but can request the availability of staff by gender.

Peer Mentor Program

GMHCN operates a Peer Mentor program that is designed to help transition individuals who are receiving care in state facilities to community living. The State of Georgia originally maintained seven state hospital facilities and there were two Peer Mentors assigned to each hospital. Currently there are now five hospitals and 14 Peer Mentors. Individuals are referred to the program by the state and GMHCN assigns a Peer Mentors for each individual assigned to the program. The peer specialists employed within this are required to complete 40 hours of training, in addition to their Georgia peer certification training. Many of the individuals who receive the Peer Mentor Program services have had multiple readmissions to the state hospitals and many have been in the hospital for more than 60 consecutive days. The Mentor meets with the individual at the hospital initially and follows their transition into the community. There is no time limit for how long someone can be engaged in this program.

> *"We are providing a continuum of care, an eco-system of care, to keep people from having to go to the hospital"*
>
> *-- Sherry Jenkins Tucker, GMHCN Director*

Data and Outcomes

The GMHCN collects information on utilization of services as part of their monthly reporting requirements with the state. The monthly reports have not been analyzed to measure impact on hospitalization rates and ED use. GMHC reports that they have results from an annual self-report consumer survey of their GMHCN Peer Mentor Program (2013-2014 survey). The latest survey shows that only 37 percent of the respondents said that they were re-hospitalized after being involved in the program, and 90 percent said peer mentor helped improve their quality of life. Unfortunately, the heterogeneity within the sample of program participants did not allow for the survey to assess whether meaningful engagement with program had any effect on re-hospitalization. Georgia state leaders report that in 2014 the Peer Support Wellness

Centers and the Peer Mentor Program have successfully reduced hospitalizations below the state's baseline targets. Unfortunately, no further data is available since services are not racked on an encounter basis.

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Georgia Mental Health Consumer Network
246 Sycamore Street
Decatur, Georgia 30030
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URL: http://www.gmhcn.org

</div>

NEW YORK ASSOCIATION OF PSYCHIATRIC REHABILITATION SERVICES, INC.

Program Background

The New York Association of Psychiatric Rehabilitation Service's (NYAPRS) Peer Bridger Program was established in 1994 through a contract with the State of New York. NYAPRS is recognized nationally as the initiators of the original Peer Bridger Program. There are a number of other organizations that offer similar services, but many are not affiliated with, nor follow, the NYAPRS model. Initially, NYAPRS was funded to provide PSS to individuals who had a history of lengthy stays at one of five New York State psychiatric hospitals. The peer specialists, known as "Peer Bridgers," work with individuals in the hospital and then continue to work with them in the community. Recent changes in the state's reimbursement mechanism have influenced NYAPRS to accommodate changes to their original model. For example, in 2009 NYAPRS partnered with the Optum Health managed care organization in a Chronic Illness Demonstration Project to serve Medicaid populations. Following that partnership, NYAPRS partnered with Optum Health in a long-term program to implement the Peer Bridger model throughout New York City and Long Island. The goal of this collaborative project is to find individuals who are high users of EDs and crisis centers and to provide them with Peer Bridger services. Unlike the traditional Peer Bridger Program, Peer Bridgers who work in the Optum program often have to find and engage individuals within the community, rather than starting in an inpatient setting. Similarly, in 2014, Health First, another Medicaid managed care payer, also contracted with NYAPRS for Peer Bridger services. The Health First service contract shares many of the features of the Optum Health program including engagement of individuals within the community. The Health First contract includes a telephonic case manager that works with peer specialist in the coordination of an individual's care.

> *"We were the first Peer Bridgers in the world. We've been doing this work for over 20 years!"*
>
> *-- Tanya Stevens, Director of the NYAPRS Peer Bridger Program*

NYAPRS PROGRAMS THAT IMPACT HOSPITALIZATION AND ED USE	
PSS Categories	**NYAPRS Programs**
Crisis and Respite Services	
Transition in Levels of Care	• Peer Bridger Program
Community-Based to Promote Recovery and Resiliency	• Peer Bridger Program • Critical Time Intervention Housing

Service Catchment Area

Through contracts with the State of New York, NYAPRS delivers Peer Bridger services in the following counties: Albany, Broome, Queens, Suffolk, and Westchester. Through the managed care contracts, services are delivered in Long Island, and New York City.

Peer Support Services Model

The manualized components of the Peer Bridger program were developed by NYAPRS. Information on the components of the NYAPRS Peer Bridger Model are described in subsequent pages of this case study.

Service Recipients

Individuals who receive Peer Bridger services engage in the program voluntarily and have a history of mental health and/or substance use conditions. Through the New York OMH contract, Peer Bridgers meet with and work with clients in the state hospitals and then in the community.

Through the managed care contracts, individuals with frequent and recent hospitalizations are referred to the Peer Bridger program. In most cases, Peer Bridgers first engage the individual in the community. Much more time is spent on outreach and engagement of referred individuals.

> *"Peer Bridgers are part of our team. They are integrated into our workflow."*
>
> *-- Bill Dixon, Executive Director of Albany State Hospital*

Training and Certification of Peers

The State of New York is currently in the process of developing training, certification and reimbursement standards for PSS. However, as of July 2014, the State of New York has not implemented any requirements for training and certifications of peer specialist; peer specialist services are not Medicaid reimbursable in New York. NYAPRS has established their own training and supervision requirements for individuals who work as Peer Bridgers in their programs. Peer Bridgers are trained using an established manualized training curriculum that includes 40 hours of training and covers the core competencies for the NYAPRS' Peer Bridger Program. Once training is completed, Peer Bridgers are provided with weekly telephonic supervision and in-person meetings every 2-3 weeks with the Director of the NYAPRS' Peer Bridger Program. NYAPRS also offers Peer Bridgers additional training on housing, entitlements, working with individuals with substance use problems, and whole health peer support service models.

Financing Services

NYAPRS maintains contracts with the state and two managed care entities to provide Peer Bridger services. The managed care contracts include Optum Health and Health First, both serving Medicaid-covered lives. Each contract has different criteria for covered services. Clients are identified through referrals from the state or managed care companies. Historically, NYAPRS has received bundled payments for services to designated populations. NYAPRS leadership note that as the New York State Medicaid system evolves, it is likely that reimbursement for PSS will change. Changes may include billing for fee-for-service reimbursement and establishing electronic health record capabilities. Additionally, New York is expected to begin certifying and reimbursing peer specialists in late 2015.

Featured Programs

> *"Peers are great at engagement, activation, and outcomes. People are leading happier lives and getting less intrusive services."*
>
> *-- Optum Managed Care representative for New York*

Peer Bridger Model

Peer Bridger services are a time-limited model of care. The length of stay in the program varies by contract and service recipient needs. The model has four distinct, yet overlapping, phases. Peer Bridgers work with individuals to get through the phases, often starting the Peer Bridger relationship while the person is still in the hospital. The phases are:

Phase 1: Engagement. Ideally, the engagement process begins when an individual is still in the hospital. However, this is not always feasible and then engagement begins with outreach in the community. In this phase the Peer Bridger helps establish a relationship that is grounded in recovery principles and supports a transition to community living. The Peer Bridger does not rely on existing medical records or other clinical summaries to understand the individual that they are working with. Instead, the engagement is developed through a direct relationship with the individual, and not diagnosis or prior service based.

Phase 2: Crisis Intervention. Recognizing that the transition from the hospital to the community is difficult, the Peer Bridger Model defines it as a "crisis transition." Psychiatric hospitalizations can be a traumatizing experience, and can also exacerbate earlier life traumas. Regardless of whether the first contact is initiated within a hospital setting or in the community, during this phase the peer specialist works with the individual to determine their immediate needs and assess their immediate and short-term plans and goals. Helping to stabilize the person's life during this phase is the most important goal. Discretionary one-time use support funds are generally available to help during this phase.

Phase 3: Activation of Wellness Tools. The individual has completed Phase 1 and 2. They are living in a stable environment within their community. In this phase, the development of wellness and self-management skills are the key tasks. The Peer Bridger works with the individual to promote the principles of recovery using structured programs like the WRAP. Self-directed goals and ongoing plans are developed. Peer Bridgers are trained in the Stages of Change model, and they use Motivational interviewing skills.

Phase 4: Disengagement. In the final phase of the Peer Bridger Model, the focus is on completing the process of community integration and comfortably disengaging from Peer Bridger services. As the individual successfully transitions to their life in the community and natural supports are established, then the evolution from the hospital back to daily life is complete.

Adapted Peer Bridger Model

In recent years, NYAPRS has adapted their original model to accommodate the changing health care environment. Unlike the original Peer Bridger Model where a Peer Bridger initially engages with the person in a hospital setting, recent adaptations include client referrals that require Peer Bridgers to first engage with an individual within the community. More often the individuals they are asked to work with are identified by Medicaid managed care companies as high utilizers of EDs and have a history of repeated psychiatric hospitalizations. These individuals often have complex needs, including co-occurring substance abuse and homelessness. Peer Bridgers working within these programs are trained as "recovery coaches" to address substance use issues, as well as mental health conditions; they are also educated as housing specialists. All program participants are voluntary, but referred by the state, Optum Healthy, or Health First.

In the Health First program there is a telephonic case manager who alerts the Bridger program of a new enrollee in the program. Peer Bridgers and the Health First case managers have biweekly meetings where they discuss specific "members" (consumers) that they share, and reach out to one another while working with the consumer.

Housing has been a growing challenge for the individuals that NYAPRS Peer Bridgers work with. To address this challenge, NYAPRS has recently implemented the Critical Time Intervention (CTI) Housing Program. CTI is a well-researched practice designed to prevent homelessness among people suffering from severe mental illness. CTI is a time-limited intervention, lasting nine months. The phases of CTI, Transition to Community, Try-Out, and Transfer of Care, are each roughly three months. CTI targets repeat and high-cost users of inpatient services.

> *"When I was sick, 'hope' wasn't a word in my vocabulary. I wish I had a Peer Bridger who helped me."*
>
> *-- Peer Bridger working in NYC*

Data and Outcomes

The NYAPRS Peer Bridger program does reduce the rate of re-hospitalization. The Optum Health's behavioral health sciences group reports that after including NYAPRS Peer Bridgers into their managed care program, there was a 47.9 percent decrease in the use of inpatient services; the average number of inpatient days decreased by 62.5 percent, from 11.2 days before NYAPRS involvement to 4.2 days after NYAPRS Peer Bridger involvement; and outpatient visits increased by 28 percent among individuals served by Peer Bridgers. The overall behavioral health cost decreased by 47.1 percent (report from July 2013). In a previous study of the NYAPRS Peer Bridger program, a cohort of 176 individuals who participated in the NYAPRS Peer Bridger Program to transition from the New York State hospital into the community were assessed 1 year after leaving the hospital setting (from 2008-2009). These data show that approximately 71 percent of the individuals were able to maintain their tenure in the community and were not re-hospitalized.

> *"As a Bridger, sometime I say to people, 'Been there and done that. I just don't have the t-shirt.'"*
>
> *-- Peer Bridger working in Albany*

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Peer Bridger Program
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OPTUM, PIERCE COUNTY REGIONAL SUPPORT NETWORK

Program Background

Since 2009, Optum has served as the RSN (Optum Pierce RSN) for Pierce County, Washington. As the RSN, Optum coordinates mental health care for Medicaid beneficiaries (an eligible monthly population of approximately 135,500) through a network of inpatient, outpatient and residential treatment providers. In this role they are responsible for developing the health care system that serves the most severely ill behavioral health consumers in region. In the past 6 years, Optum Pierce RSN has made a commitment to integrating PSS into their service provider networks. Through direct contracting with providers, Optum Pierce RSN has changed their county mental health system to be recovery oriented and staffed by a growing portion of Certified Peer Counselors (a.k.a., peer specialists) who work alongside traditional mental health providers and within systems of care. Within the Optum Pierce RSN, peer specialists work in ED settings, in crisis centers, and in outpatient provider settings. Peer specialists work with adults, youths, and families. Optum has worked with the state to establish certification guidelines for peer specialists and helped to train this workforce in Pierce County and in other parts of the state.

> *"Before Optum began working in Pierce Country, peer support services were not valued. Now, for every intervention someone is asking, 'How can we involve peer partners in this?'"*
>
> *-- Pierce County Behavioral Health Provider*

OPTUM PIERCE RSN PROGRAMS THAT IMPACT HOSPITALIZATION AND ED USE	
PSS Categories	**Optum Pierce RSN Programs**
Crisis and Respite Services	• Crisis Triage Centers • Evaluation and Treatment Centers • Top 55 ED Utilizers • ED Diversion Program • Mobile Outreach Crisis Teams
Transition in Levels of Care	• Peer Coaches for Community Transition • Residential Facility Community Re-entry • Jail Community Re-entry • Juvenile Detention Services
Community-Based to Promote Recovery and Resiliency	• Mobile Integrated Health Care • Recovery Centered Housing (PORCH)

Service Catchment Area

Optum Pierce RSN coordinates mental health care for Medicaid beneficiaries in Pierce County, Washington, through contracts with a network of inpatient, outpatient,

and residential treatment providers in the region. Optum also operates a national program for behavioral health management that promotes the role of PSS in other markets.

Peer Support Services Model

Optum Pierce RSN has implemented their own curriculum for training peer support specialists based on their national Optum Health service model. Most of the peer specialists employed within the Optum Pierce RSN are trained by Optum and they receive additional training from the provider organization that they are employed within.

Service Recipients

Optum Pierce RSN serves Medicaid beneficiaries with mental health conditions. They are in the process of expanding beyond a focus on behavioral health conditions and promoting a whole health approach that addresses the physical health needs of persons with mental health and/or substance use conditions. In some cases, peer specialists work with individuals without Medicaid benefits to complete paperwork for their entitlements.

> *"I've worked in other states and in other counties within Washington. I can tell you that Pierce County is unique. Here, peer specialists are integrated into our work. Optum has promoted in Pierce County the value of peers."*
>
> *-- Director of a Community Behavioral Health Center in Tacoma, Washington*

Training and Certification of Peers

Optum Pierce RSN conducts its own training of peer specialists within the network. Optum leadership describes the training as manualized but dynamic enough to cover new topics as the health care system evolves. The training meets Washington State certification standards for peer providers. Optum is one of three training sites within the state. Forty hours of training is required, as well as continuing education credits.

Approximately 200 peers are employed within their Pierce County provider network. As of July 2015, Optum Pierce RSN has trained nearly 500 peer specialists and continues to conduct training sessions approximately 2-3 times a year. All graduating peers are welcome to receive ongoing Optum Pierce RSN newsletters that list relevant changes in the field and employment opportunities for graduates.

Financing Services

Optum Pierce RSN is contracted by the State of Washington. Most PSS are paid for through contracts with network provider organizations using a modified fee-for-service model. Provider organizations are prospectively paid and encounters are

tracked and adjudicated against these payments. Optum Pierce RSN contracts with providers in Pierce County and develops detailed description of the peer services that are being contracted for. Optum also uses some of their administrative dollars to promote the role of peer services across their network and the community. In order to support the role of peers in provider organizations, Optum has made the administrative decision to pay peers at the same rate as Masters-level clinicians. It is up to the providers who employ peer specialists to determine salary.

Featured Programs

> *"We see that putting peers into situations where they have no lived-experience is not helpful. For example, when we put peers without criminal justice experience into the criminal justice system it didn't work. So then we decided to staff the peer support services with peers who had been arrested, been in jail or prison. Ta da! It was amazingly effective!"*
>
> *-- Director of a community behavioral health agency within the Optum Pierce County RSN*

Crisis Triage Center

As a part of their network of care, Optum Pierce RSN contracts with RI (an Arizona-based provider organization) for the Recovery Response Center in Pierce County. This was the first Triage Center in Washington State to be staffed with 50 percent peer specialists. Individuals are mostly referred by first responders and EDs. Of the 2,500 average guests per year, only 2 percent are hospitalized.

> *"Hospitalization is traumatizing! We needed an alternative. If it weren't for peer support services, so many people in our community would be lost within the maze of the health care system."*
>
> *-- Pierce County Peer Specialist*

Evaluation and Treatment Centers

Optum Pierce RSN has supported the opening of four16 bed Evaluation and Treatment Centers. This resource serves as a crisis evaluation and management facility. Peer specialists work side-by- side with other providers on the treatment team.

Top 55 Emergency Department Utilizers

This program was developed to serve the most frequent utilizers of emergency psychiatric services. Peer specialists play a key role in this program. The program is designed to serve children and adults, and a team is available 24 hours/7 days a week to provide outreach and services for this population.

Emergency Department Diversions

In this program, peer specialists work with mental health professionals in local EDs to rapidly assess and divert as indicated, individuals who are seeking ED care. Within this program, of the 1,040 individuals seen (during a 14-month period), only 6.2 percent were hospitalized.

Peer Coaches for Community Transition

This program helps support individuals who are in the hospital to transition to the community. The program assigns a peer specialist who works with the individual both within the hospital setting and then in the community following hospital discharge.

Mobile Outreach Crisis Teams

As part of this program, a mobile van travels to community locations to address the needs of individuals who are experiencing psychiatric crisis. Teams of clinicians and peer specialists work together. Optum Pierce RSN reports that this program has helped reduce involuntary detention by 31.1 percent.

> *"We are the hope. For the people we work with, we are the model for recovery."*
>
> *-- Pierce County Youth Peer Specialist*

Residential Facility Community Re-entry

This is a PACT Team model in which 70 percent of the staff are peer specialists. Since the program began 5 years ago, Optum Pierce RSN reports that they have doubled their original investment, resulting in over $3 million in savings.

Jail Community Re-entry

This program is designed to help incarcerated individuals successfully transition from jail settings back to the community. Peer specialists engage individuals while they are still involved in the criminal justice system and support them once they are back in the community. This program relies on peer specialists with a history of mental health conditions and who have been criminal justice system-involved. Optum Pierce RSN reports that one year after starting the program they saw a 72 percent reduction in re-arrests.

Optum Pierce RSN also supports a similar program in which daily jail bookings are reviewed for individuals with a past history of mental health treatment. Peer specialists contact individuals while they are still in jail and help them transition back into the community, enroll for Medicaid benefits and access needed health and community-based services.

Juvenile Detention Services

In this program, certified peer youth mentors engage with detainees who are struggling with mental health issues. Peer specialists help reunite families and address safety planning with the youth.

Mobile Integrated Health Care

Optum Pierce RSN has partnered with a local hospital to develop a mobile outreach van that provides on-site primary care services at local behavioral health centers. This van is staffed by nurse practitioners and peer specialists. The van offers routine primary care services. As of June 2015, this program has served 1,174 individuals, and of these individuals: 49.5 percent have reduced their body mass index; 50.0 percent show decline in their Hemoglobin A1c; and 56.3 percent show reduction in their lipid counts.

Recovery Centered Housing (PORCH)

Fifty percent of the staff working within this housing program are peer specialists. The program helps individuals with mental health conditions find and maintain stable housing. Optum Pierce RSN reports that 88 percent of individuals who have enrolled in this program now have stable housing.

Data and Outcomes

Optum Pierce RSN's integrated provider network has allowed them to collect data on service utilization including hospitalization, ED use, and health care costs. Their data shows that after introducing PSS into their repertoire of services, they have achieved an estimated $21,600,000 savings in excess service utilization costs.

An analysis of Pierce County services in 2013 shows that following the inclusion of PSS across provider contracts, among individuals served by Optum there was a 31.9 percent reduction in hospitalizations (estimated $12.1 million saving in 5 years). Additionally, follow-up by a provider after discharge from a hospitalization rose from 20 percent to 70 percent. There was a 32.6 percent reduction in involuntary admissions with an estimated savings of $8.4 million over 5 years. There was a 32.1 percent reduction in 30-day readmission rate (estimated $1.1 million savings in 3 years).

Additional data and outcomes are provided for the specific programs described in the *Featured Programs* section of this case study. **(Statistics provided by G. Dolezal and F. Motz. Data dated August 1, 2013.)**

REDUCING UNNECESSARY HOSPITALIZATIONS, AND ED UTILIZATION				
	Prior Year FY 2009	**Optum FY 2010**	**Optum FY 2011**	**Optum FY 2012**
Individuals Served • 32.0% increase in individuals served annually	12,121	15,262	15,410	16,005
Total covered county population		1,399,846	1,492,221	1,535,745
Reduction in Hospitalization Admissions • 32.3% reduction in hospitalizations • $7.3 million est. cumulative 3-year savings	123 monthly	99 monthly	79.25 monthly	71.6 monthly
Involuntary Treatment Act (ITA) Reduction • 31.1% reduction in ITA • $5.0 million est. cumulative 3-year savings	83.6 monthly	56.8 monthly	55.8 monthly	57.58 monthly
Re-admission Rate/30 Days • 26.5% reduction in re-admission rate • $0.5 million est. cumulative 3-year savings	12.6%	8.6%	10.75%	8.45%
Inpatient Bed Days/1,000 • 35.0% below state average • $12.0 million est. cumulative 3-year savings	19.60	12.13	12.37	13.73
Cumulative reduction percentages in column 1 are calculated as the average reduction over the 3-year Optum period compared to the prior year. Bed days/1,000 is based on the total covered county population. Cost savings calculations use average length of stay and/or daily unit costs based upon the prior year experience.				

Table is an excerpt from:
https://www.optum.com/content/dam/optum/resources/whitePapers/BSPUB0119S003JV_PierceCty-WR.pdf.

Optum, Pierce County Regional Support Network
3315 South 23rd Street, Suite 310
Tacoma, Washington 98405
Phone Number: (253-761-3084)
URL: http://www.optumhealthpiercersn.com

RECOVERY INNOVATIONS

Program Background

RI was founded in 1990. This case study focuses primarily on RI programs in Maricopa County, centralized in Phoenix, Arizona. In many of RI's programs, peer specialists (PS) work in integrated teams with nurses, psychiatrists, psychologists and social workers; some RI programs are entirely peer-run. They maintain one of the largest peer specialist workforces in the world. Peer specialist constitute 65 percent of the workforce at RI (approximately 500 peer specialist employed). The RI service model was initially developed to address the needs of persons experiencing psychiatric crisis. RI's Recovery Opportunity Center maintains a robust training program that supports the education and certification of their peer specialist workforce.

RI contracts with organizations and systems outside of Arizona and has developed programs and services in six states and in New Zealand; and the Recovery Opportunity Center has provided training and consultation in 27 states and five other countries. Impressively, the RI Crisis and Respite Centers "Recovery Response Centers" are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JACO) as a level 1 sub-acute health care facility.

> *"For over a decade Recovery Innovations has been the employer of the largest peer specialist workforce in the world. The Veterans Administration has recently taken that title from us, but we are involved in training their workforce too!"*
>
> *-- Lisa St. George, Director of Recovery Practices, Recovery Innovations of Phoenix*

| RI OF MARICOPA COUNTY PROGRAMS THAT IMPACT HOSPITALIZATION AND ED USE ||
PSS Categories	RI Maricopa County Programs
Crisis and Respite Services	• Recovery Response Centers • Peer Recovery Teams • Recovery Connections Phone Line
Transition in Levels of Care	• Peer Advocacy -- Hospital Transition Services
Community-Based to Promote Recovery and Resiliency	• Wellness City • Recovery Education • Supportive Housing

Service Catchment Area

Programs are run throughout Maricopa County, Arizona. Many are based in Phoenix. Through contracts, RI provides peer specialists in six states and New Zealand.

Peer Support Services Model

RI describes their services as being based on their Recovery Opportunity Center's Peer Employment Training for Certified Peer Specialists and a Whole Health Model, both developed by Recovery Opportunity Center.

Service Recipients

In the State of Arizona, RI provides services to over 10,000 adults with serious mental health and substance use conditions each year. Recipients are Medicaid eligible or qualify for other publicly funded mental health services. Most of the RI programs focus on adults, but some programs serve family members and transitional-aged youth.

> *"Our Peer Services focus on recovery. This is a shift in perspective. It shifts the perspective of all the other providers we work with."*
>
> *-- Peer Specialist in the Housing program*

Training and Certification of Peers

As of June 1, 2015, RI's Recovery Opportunity Center has trained over 7,000 Peer Specialists worldwide. Their training curriculum includes 80 hours of training over 2 weeks. All staff (including non-peers) must complete 40 hours of recovery oriented new employee training as a requirement of RI employment. The Recovery Opportunity Center Peer Employment Training program costs $1,295 per-person. However, in Arizona, any individuals who receive a referral from the Department of Vocational Rehabilitation are eligible to have their training paid for, if it is part of their service plan. The RI Peer Employment Training curriculum is a proprietary manualized program. RI has cross-walked the training requirements with their Arizona certification requirements, as well as those of many other states that certify PSWs, to ensure that certification requirements are fully met. RI has contracts to conduct peer specialist training in the states of Louisiana, Pennsylvania, Minnesota, Tennessee, California, Delaware, North Carolina, and is the primary trainer for the VA.

Financing Services

RI reports annual revenues of over $63 million across the company. Funding sources within Maricopa County include the State of Arizona Department of Health Services through a contract with the Mercy-Maricopa Integrated Care/AETNA Regional Behavioral Health Authority (RBHA), the Arizona Rehabilitation Services Administration, and the U.S. Department of Housing and Urban Development. The RBHA is a Medicaid-funded program, and RI serves as a crisis and recovery-based services provider. As a requirement of Medicaid funding, all services must be compliant with HIPAA. The RI programs have been able to sustain contracts with the RBHAs despite changes to the RBHAs entity. According to RI leadership, this is due in large part to RI's

reputation and ability to effectively manage community-based recovery services. In other states, RI contracts with various funding authorities to provide a range of programs including crisis services, peer specialist training, housing, respite, and resource development. RI does not bill third-party private health insurance plans.

Featured Programs

> *"There is great consistency across Recovery Innovations' sites within and outside of Arizona. We find an 85-90% fidelity to our model across sites. All our materials across sites have the same look and feel. Our staff go through the same core training regardless of which state they are in."*
>
> *-- Lisa St. George, Director of Recovery Practices, Recovery Innovations Phoenix*

Recovery Response Centers

The Recovery Response Centers is a three-facility program with the following components: Front Room (walk-in crisis center); Retreat (a 23-hour observation center); and the Living Room (licensed as a crisis stabilization facility). Peer specialists work alongside other health care professional within the Centers.

In the Front Room the initial behavioral health assessment is completed. A peer specialist is the first person the individual meets when they enter the Front Room. Individuals who are seen in the Front Room and need additional time to plan next steps are invited to stay in the 23-hour Retreat. Those who need longer stays are registered in the Living Room, where they can stay several days.

The Living Room Concept was created by RI as an alternative to traditional crisis services. The Living Room provides a space where individuals who are having a difficult time can become a guest. They receive comfort and hope from a team of peer support specialists.

The Centers emphasize a strength-based approach to all services. For example, the rooms in the Center where participants stay are labeled with a recovery-based name such as hope, strength, and resiliency. Staff in these programs are based in open areas, and engagement with the participants is encouraged at all times. These Centers are accredited by JACO.

> *"We show people that there is life after hospitalization."*
>
> *-- Peer Specialist within one of the Recovery Response Centers*

Community Response Team

This mobile crisis service responds to people in their home or other community locations. The Crisis Response Team is staffed with peer specialist and traditionally trained psychiatric staff. Peer specialist offer up to three follow-up visits to fully resolve

the situation. The Community Response Team (CRT) can also respond to hospital EDs and police requests.

Recovery Connections Phone Line

This 24 hours/day, 7 days/week telephonic crisis services is staffed by Peer Specialists who address calls from consumers and are able to dispatch a CRT or make a warm hand-off with other crisis professionals as needed.

Peer Advocacy Services

These services are hospital-based PSS. Their goal is to work with individuals who are currently in the hospital and help in the development of recovery-oriented discharge plans and ongoing recovery plans to support re-integration into the community. These services are intended to reduce the need and likelihood of hospital readmissions. The Peer Advocacy services work with the Peer Recovery Teams to coordinate and provide PSS in the community to foster resiliency and promote recovery. On average, Peer Specialists on the Recovery Team will maintain a caseload of about 30 participants. The hospital tracked outcomes the first year that Peer Support came into the hospital through RI. Those outcomes included a 56 percent reduction in recidivism, a 47 percent reduction in restraint use, and a 36 percent reduction in seclusions.

> *"We focus on what is strong; not what is wrong. Unlike traditional providers, when we write in the electronic medical records we describe how the person is doing rather than about their problems."*
>
> *-- Peer Specialist in Peer Advocacy Services program*

Wellness City

The RI Wellness City programs are open to individuals who have RI services built into their treatment plan. Participants in these services (referred to as "citizens") have a wide array of programs and activities that support recovery including: educational life skills classes, city hall meetings, employment support, career workshops, linkage to community resources, housing support, personal wellness coaching, computers access and social events. Fitness rooms, exercise equipment, and health-related programs are also available.

Recovery Education Center

The Wellness City also includes the Recovery Education Center. The Center offers a variety of educational classes and workshops. Participants can earn Vocational Educational Certificates by enrolling in specific programs. The Center is classified as an Arizona Licensed Private Postsecondary Vocational School. The Center meets GED testing requirements and supports participants' educational advancement.

Housing Services

This program is designed for persons on Medicaid with mental health problems. Every person in this program has a peer specialist assigned to them. Individuals meet with their peer specialist weekly at first for 1-1.5 hours a week, reducing duration and frequency of meetings over time. Individuals may graduate after 1-2 years from the program. This program has fidelity to SAMHSA Supportive Housing model. Use of peer specialist is what makes it unique. RI has replicated this program with peer specialist in other states.

Data and Outcomes

While RI maintains medical records for the consumers they serve, they do not specifically track data on ED use and hospitalization. The data directly tracked by RI are related to contract requirements and JACO accreditation standards. However, they note that sometimes the agencies that contract with RI will provide data. For example, in Maricopa County, the RBHA reports that following implementation of a recovery mission and Recovery Response Center in 2002, hospitalizations decreased from a high of 24 percent to 10 percent within a year (diversion of 1,080 hospital admissions), representing an estimated savings in hospitalization costs of $10,000,000. Of those individuals who are served at one of RI's Crisis Respite Centers, less than 25 percent are hospitalized. Between 2003 and 2004, RI was able to reduce hospitalization rates by 25 percent within 6 months in two other locations where they implemented Recovery Response Center crisis services.

Outside of Arizona, RI reports that for one of their contract sites in Ellendale, Delaware (Beebe General Hospital), reported that after the RI Recovery Response Center began to do business in their community, ED dropped by 50 percent for persons with behavioral health conditions. Likewise, in July 2010, RI was contracted by Wenatchee, Washington. In the first 6 months of RI operations, the number of persons enrolled in Medicaid increased by 40 percent and the number of hospitalizations decreased by a third of its previous level.

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Phoenix, Arizona 85006
Phone Number: (602) 525-3003
URL: http://www.recoveryinnovations.org/riaz/rihomepage.html

4. CASE STUDY FINDINGS AND CONCLUSIONS

The PSS described within the site visit case studies (Chapter 3) demonstrate four very different types of program models that are actively engaged in fostering improved recovery status and behavioral health outcomes for those served. These programs help address and inform the three questions that frame this study of how peer support service models help reduce preventable psychiatric hospitalizations, re-hospitalizations, and ED utilization. Based on the review of existing peer support service programs across the United States and these case examples, it is evident that they have established an emerging role in the health care systems of many states.

As illustrated by the case examples in this study, there is a range of service models and roles that Peer Support Specialists are engaged in. To illustrate the spectrum of PSS approaches and models, a framework of the types of services that are applicable to the question has been developed. This includes programs that provide services for crisis and respite care; level of care transitions; and community-based recovery supports.

A summary of the range of programs evaluated is included in Table 6 below.

TABLE 6. Site Visit Programs by Type				
	GMHCN	**NYAPRS**	**Optum -- Pierce County**	**RI**
Crisis Respite Programs	• Peer Support Wellness Centers • 24/7 Crisis Phone lines		• Crisis Triage Centers • Evaluation and Treatment Centers • Top 55 ED Utilizers • Mobile Crisis Outreach Teams	• Recovery Response Centers • Peer Recovery Teams • Recovery Connections phone line
Level of Care Transition Programs	• Peer Mentor Program	• Peer Bridger Program	• Peer Coaches for Community Transition • Residential Facility Community Re-entry • Jail Community Re-entry • Juvenile Detention Service	• Peer Advocacy Hospital Transition Services
Community-Based Recovery Supports	• Daily Structured Recovery Education Programs	• Peer Bridger Program • Housing Peer Specialists	• Mobile Integrated Health Care • Recovery-Centered Housing	• Wellness City • Recovery Education • Supportive Housing

The outcomes measured for these services types are variable and have methodological challenges. All of the outcomes reported by these programs are generally derived from self-report or administrative data. There were no formal evaluations that used quasi-experimental or RCT approaches. Two of the programs (GMHCN and NYAPRS) do not have specific staff that are responsible for outcome evaluations, and they do not receive any funding or administrative support for these functions. One of the programs (RI) has a robust accreditation commitment and many of their outcomes evaluations are linked to these accountability standards. The Optum program has the greatest level of commitment to measuring outcomes and they have access to utilization and other administrative data, and both local and national staffing resources, to support these tasks.

Crisis Respite Programs

Crisis respite programs are designed to provide a safe and stable environment for someone experiencing a psychiatric emergency. PSS in these crisis settings foster a safe relationship that allows individuals to engage with others who have had similar experiences. In team-based crisis care such as evaluation centers and mobile outreach programs, peers work collaboratively with clinicians and are effective at engaging individuals and helping to develop person-centered plans.

Three of the four programs reviewed have some type of crisis respite programs. These include telephonic crisis and warm lines as provided by GMHCN and RI, both of which are staffed by peer specialists and collocated within crisis facilities. Various forms of crisis centers were also observed, including the GMHCN Wellness Center and the RI Recovery Response Center. In varying degrees these programs are focused on wellness and recovery in addition to specific crisis focused services. Optum contracts for a crisis center and an evaluation and treatment center. The crisis center programs are peer staffed, while the others are hybrids programs using both clinical and peer staff. Optum also supports a range of other crisis programs including mobile crisis outreach teams, which include peer staff, and high utilizer care management programs.

Across the crisis and respite services there is not a consistent model that is predominant. Each of the programs provides staff training and has employee guidelines. However, these are not specific protocol-based services and there appears to be considerable variability across programs. Staffing models, including peer-only as well as peers and professionals integrated in a service setting, are also variable across these programs.

As noted above, there are significant challenges and limitations in the evaluation of outcomes among many of the programs reviewed. The GMHCN program primarily uses self-report data on personal health information and program participation satisfaction. Their participants self-report a re-hospitalization rate of 37 percent at any time within the past year. They also have some state-reported outcome data that indicates that the

number of hospitalizations has declined below anticipated trended rates. However, since they do not have specific encounter-based service utilization data, it is difficult to directly attribute these outcomes to specific crisis respite services. The results for RI are similar in that they are not specifically tracked to internal outcomes at the client level. However, the results of their reporting to their contract RBHA supports an overall reduction of hospitalizations in the target year of 14 percent, and 1,080 hospital diversions are noted for the population served. Additionally, based on currently trended measurements, they report that 75 percent of those receiving care in their crisis center self-reported that they did not require admission to a psychiatric facility. The best results for crisis respite services are provided by Optum. This is due in large part to their role as network administrator across multiple programs and state contractual requirements. Optum reports system-wide results of savings in both total dollars and per-case utilization. For example, they note that they have been able to reduce hospital admissions by 32.3 percent for an estimated cumulative savings of $7.3 million over a 3-year period. This is cost-trended data based on historical utilization patterns and service costs.

Level of Care Transition Program

Level of care transition programs are designed to help individuals who are hospitalized for mental health conditions successfully transition to outpatient care and return to the community. These programs provide a peer support specialist who can both assist the recipient of service and help advocate for their community needs. This is accomplished in part through a supportive peer relationship that promotes the linkage and connection to ongoing care and community support resources.

Each of the sites reviewed operates one or more programs to support level of care transitions. Generally these are services that are focused on helping individuals transition from psychiatric hospitals to lower levels of care and community living. Three of the programs are based in states (Georgia, New York, and Arizona) that continue to use state psychiatric hospital care for longer term stays. However, these transition services are deployed in both state and community psychiatric hospitals.

These level of care transition programs are variously described as "peer bridger" (NYAPRS), "peer mentor" (GMHCN), and "peer coaches" (Optum). Several organizations also used the term "peer bridger" to describe level of care transition services. Across the programs reviewed, the NYAPRS Peer Bridger program has the most structured model of services. This model describes four phases of service that guide the work of the peer specialist. The other programs do not have as clearly structured an intervention model and their work is more open-ended.

The outcomes of the level of care transition programs are monitored and reported in various ways by the different organizations. Again, there are challenges and limitations in the way outcomes are measured and reported. NYAPRS reports outcomes based upon an early study from 2008-2009 that was conducted internally and not

repeated. In this study, they report that 71 percent of the individuals served were able to maintain community tenure without readmission throughout the study period, but they do not have baseline data for comparison. More recent data have been reported by one of their managed care payers (Optum), and the results indicate a 62.5 percent reduction in hospital length of stay, and a 47.9 percent reduction in inpatient services among participants. This is based on comparison with the plan and state's historical data. Additionally, supporting the successful transition to lower levels of care, Optum also reports increased outpatient utilization by 28 percent among those receiving peer bridger services. Based on self-report data, GMHCN reports that there is a 90 percent satisfaction rate with their peer mentor services, and within the year 37 percent of service recipients reported re-hospitalization. Without longitudinal or comparison data it is difficult to interpret the Georgia statistics. Optum Pierce County reports that over a 3-year period of time their readmission rate has declined 26.5 percent from baseline, and they have realized one-half million dollars in savings as a result of these reductions in hospital utilization.

Community-Based Recovery Supports

Community-based recovery supports are those services that foster ongoing resiliency and well-being. These can take many forms, including ongoing PSS as well as the development of other peer and community supports. These activities also promote engagement, activation, and ongoing self-management for behavioral and physical health conditions. Over time, these services are less formal as individuals assume more community-based recovery activities.

All of the programs reviewed for this study provided some forms of community-based recovery supports. One of the more frequently described challenges by the organizations that provide these services is the need for stable housing. NYAPRS, Optum Pierce County, and RI all provide some sort of housing resources as part of their programs. RI provides temporary housing resources in a designated apartment complex to help foster stability for those in transition and crisis. These are short-term supportive housing resources that are linked to the continuum of their services. NYAPRS also has designated peer specialists who can assist in housing transitions. Pierce County Optum's provider network offers community housing support programs that are linked to their provider organizations and local social service agencies.

Community-based resources are also a fundamental component of recovery supports. GMHCN provides recovery education programs within their wellness centers. These are daily structured programs that provide both direction and support to foster community tenure and recovery self-management. RI provides a campus-like setting for ongoing recovery support activities and describes the participants in their programs as "citizens."

Measuring the outcomes of ongoing community-based recovery supports is particularly challenging. In Pierce County, Washington, based on the addition of peer

services, Optum is able to measure community engagement through improved rates of clinical provider follow-up after discharge (50 percent increase), and reduced hospital readmissions (32.1 percent over 3 years) when compared with baseline trends. Other programs also report reduced re-hospitalization rates, but it is difficult to assess how much this is attributed to specific community recovery programs.

Measuring and determining the outcomes of specific PSS is difficult. While programs and systems are able to report reduced admissions, declining readmission rates, decreased ED utilization, and lower rates of necessary admissions from those seen in crisis and community settings, it is challenging to identify specific interventions that account for these results. A detailed review of these challenges is reported in the discussion below.

Results from Site Visits

The findings of this study suggest that there are a range of PSS programs currently operational across different states. The programs reviewed in this study demonstrate promising, although not always well documented results in these areas. Many PSS programs describe their mission and role as the promotion of recovery and the improvement of resiliency and well-being of those served. Four key challenges were observed from the review of these programs.

Key areas of findings from this study that merit further evaluation and discussion include:

1. Service models for PSS;
2. Funding and reimbursement models for PSS;
3. Health system integration of PSS; and
4. Measurement and reporting of the outcomes of PSS.

Each of these four factors is linked and impacts each other. Therefore, there is a cumulative effect such that variability in service models is influenced by the types and sources of funding for these services and the extent to which they are integrated into larger health systems. Finally, the result of these factors also cascades to a range of significant challenges in the measurement and reporting of outcomes. A review of each of these areas illustrates the challenges that face the continuing evolution of PSS in the United States health care system.

Service Models for Peer Support Programs

For this study, a framework of peer services including crisis/respite programs; level of care transition programs; and community-based recovery supports has been developed. Many of the organizations reviewed in this study had service programs in each of these different categories. However, variations in service models were

observed, and these programs were generally not protocol-based interventions. It is also important to note that some organizations described the necessary requirements for the flexible design of PSS and programs to be consumer-recipient defined and geared to their goals and needs. And, while this is entirely consistent with person/patient-centered goals, some peer programs differentiate between PSS from the medical or clinical model. Therefore, they propose that PSS inherently require a degree of flexibility not always seen across traditional health care services and clinical/medical intervention models.

This study has illustrated that there are a range of service models for PSS. These are in part determined by the organizations that provide them and how they fit within their mission and the spectrum of existing health care systems. Most of the organizations observed provide a majority of their services through Medicaid and other state-funded programs. Two of the program models evaluated (GMHCN and NYAPRS) can be described as consumer-run organizations. Both GMHCN and NYAPRS operate statewide services. RI is a peer-focused organization; it also incorporates traditional clinical staff in team-based care services and has both national and international training and service programs. Optum Pierce County is a part of a larger national health insurance organization, and their programs are managed care payer based. While Optum employs some peer specialists, they largely contract for the provision of services from either consumer-run organizations or clinical provider organizations.

Across the PSS programs reviewed there are a range of program models that are deployed. These also vary in the rigor of their design and the extent to which they emphasize fidelity to specific program models. In some cases the PSS programs are organized around a set of core principles that guide the service models. In other programs there are structured interventions that are based on established models of service. Across the field of PSS there are few strictly defined service models. This finding is in line with what the Institute of Medicine (IOM) has observed for many psycho-social interventions (IOM, 2015b).

As an example, NYAPRS developed and was the first to implement the peer bridger program to support individuals as they transition from hospital-based care to community-based care. This model is based on four phases of care that begin with engagement; helping individuals deal with aspects of crisis as they leave the hospital and begin to re-integrate in the community; activation of recovery and wellness tools; and disengagement when the individual can successfully maintain community tenure. NYAPRS trains their staff in this model, and they have also provided training for other programs in different states.

Each of the programs reviewed indicates that they provide some type of level of care transition services. GMHCN calls the providers of these services "peer mentors" and the others variously describe them as "peer bridgers" and "peer coaches." Across the organizations reviewed, none of their level of care transition programs has a defined a set of stages or a defined program model, except for NYAPRS' four-stage model. In some cases, there are service requirements for the frequency and duration of contacts.

In the Optum Pierce County program, these level of care transition services are linked to services provided across their network providers.

The RI crisis programs were observed in both their Arizona-based organization and also as a contracted service in the Optum Pierce County program. However, there are variations even within a single organization. For example, the RI program's state requirements for locked access to the crisis services required different service approaches in different states, as observed between Arizona and Washington.

Without clearly defined service models, it is difficult to differentiate the programs provided by the organizations included in this study. The three-level service framework proposed for this study can help differentiate the types of programs but not fidelity within services. Additionally, among the organizations reviewed in this study, there is no consistent agreement for where they fit within the continuum of health care services. This is seen in the extent to which programs operate as stand-alone PSS (e.g., GMHCN and NYAPRS), or in the extent to which they have some degree of operational integration of peer support specialists with clinicians (RI) or autonomy in the design and development of networks of services that include the full spectrum of clinical providers and facilities and PSS (Optum Pierce County). Some programs are well integrated in the systems of care and routinely share service information, while others are careful to operate outside of the traditional health systems and intentionally avoid the sharing of records and diagnostic information. As the role of PSS evolves within health care, an important challenge will be to determine the extent to which these programs are integrated as part of larger health care systems. In part, this may be resolved by the emerging funding models for these services. The extent to which PSS programs are reimbursed as health care services may require that they achieve greater integration with the overall eco-system of health care.

Funding Models for Peer Support Services

The peer support service organizations reviewed for this study operate across different funding models. As example, the GMHCN program is reimbursed on a flat service rate that is similar to a grant or a prospective payment. The volume of services is tracked and reported monthly to the state, and reimbursements are generated. NYAPRS currently operates on a similar basis, and they are currently reimbursed across multiple contracts on a global budget that covers the totality of services provided. Under this model, the time spent in outreach and engagement of program participants is covered within the overall reimbursement formula. However, as reimbursement models shift in the state they anticipate moving into a fee-for-service model whereby only direct service encounters will be reimbursed. There will be a state-established rate based on 15-minute increments of service. In another model, the Optum Pierce County program reimburses providers on an encounter basis that is fee-for-service. To support peer services, they have an established rate that mirrors that of their Masters-level providers in their network. RI receives a range of funding through several different contractual arrangements. These include service reimbursement in Arizona through the local

Medicaid vendor, through agreements with the Rehabilitation Services Administration, and also the U.S. Department of Housing and Urban Development.

As health care reimbursement increasingly moves toward value-based reimbursement, there is likely to be greater emphasis on accountability for consumer outcomes and utilization of high-cost health care services. These changes are likely to impose greater accountability and reporting requirements on PSS providers. However, there is also an emerging trend in the reimbursement of PSS that is contrary to this evolving approach. As Medicaid and other payers are increasingly responsible for the payment of PSS, they are shifting existing contracts away from prospective payments to fee-for-service approaches. This is likely being done as a way to increase the level of accountability of PSS, if only in terms of units of service provided. More systematic work may well be required before accurate assessment of the value contributed by PSS can be reliably measured and serve as a basis for reimbursement.

As the current trend for funding PSS programs evolves and shifts into fee-for-service reimbursement, there is an increasing threat that these services may not fit well within these traditional frameworks. With the advent of Medicaid-based funding for peer services, more states are moving away from prospective (grant-based) payment to fee-for-service, encounter-based reimbursement models for PSS. Some of the organizations reviewed in this study are concerned that their services are not well suited for this model of payment. When the PSS programs are community-based and involve a high component of indirect services for outreach and engagement, it will become difficult to account for the time spent in these activities unless the service definitions explicitly account for such activities. NYAPRS reports that when they begin their bridger services with individuals who have already been discharged from the hospital, there can be several hours of indirect service required to track and engage them. An important question will be the extent to which fee-for-service definitions recognize and address these requirements.

This trend toward fee-for-service reimbursement for PSS may only be transitional. As health care becomes more value and accountability based, it is likely that at least some PSS programs will become better integrated with larger delivery systems. Since PSS programs are demonstrating promising value-based results through decreasing utilization of high-cost services, systems are likely going to be drawn to including them in the continuum of health services.

Health Systems Integration

One of the principal challenges for many PSS organizations is how they fit within the existing health care systems. As seen in the examples from this study, some PSS programs are stand-alone and outside of the overall health system, some are integrated programs with peer specialists and clinicians working side by side in integrated team-based programs, and others are based in service networks. A differentiation is made by some programs that PSS should not be considered to be clinical services, and this

creates an ambiguity as to how they fit within the continuum of health care systems and organizations. Some of the organizations reviewed (NYAPRS and GMHCN) specifically avoid direct identification of a recipient's diagnosis and formal interaction with medical records documentation outside of their services. Yet, at the same time, these programs do work collaboratively with health care systems to receive referrals, specifically in the case of crisis respite and level of care transition programs. In some cases, PSS programs also support care coordination with the payer systems they are contracted with.

If PSS programs are to assume an expanding and greater role in the health services continuum, there needs to be greater clarity of how these programs fit within the overall clinical landscape. It is evident that they are an increasingly widespread component of the public behavioral health care eco-system that serves those with the most serious behavioral health conditions. Some PSS programs are also working on improving the overall health of the recipients of their services through whole health, wellness, and other integrated approaches. Yet, what is not as clear is how these services fully integrate with primary, specialty, and other health care services, nor what role they will play outside Medicaid-funded and other public behavioral health systems for people with the most serious behavioral disorders.

There is a caution among some PSS programs to preserve their services as independent from the traditional clinical/medical model. Remaining independent from the traditional clinical system has been an important historical distinction for these peer-delivered services. However, as more care is delivered within clinical teams, it will be necessary to better define their role as members of the extended care team and the care continuum. It was not clear from the programs we observed how best to integrate these services with the overall systems of care, and this may be due in part to the lack of formally developed and tested peer support service interventions and protocols. Additionally, it is also important to note that some peer specialists believe that keeping peer services distinct from the formal clinical system is a key component of what makes PSS programs effective.

Program Outcomes

The measurement and assessment of peer-delivered services is difficult and challenging. This is due in part to a combination of factors that include the lack of established service models, variable outcome goals, and ineffective measurement tools. The IOM (IOM, 2015a) has cited the need for a set of outcome vital signs for all health care. While it is essential that PSS programs evaluate outcomes that include elements like recovery and resilience, well-being, and quality of life, they are not specifically included in the IOM's framework for this set of vital signs or outcomes. Another recent IOM report (IOM, 2015b) more directly examines the current state of psycho-social interventions including PSS, and has also noted the need for better defined interventions, and more consistently measured outcomes for these services. Again, the

outcomes of PSS and the accountability of these programs must fit within the continuum of health services and other psycho-social interventions.

As noted above, there is a lack of a consistent service model across each of the three levels of programs examined in this study. For crisis and respite services this range includes mobile intervention teams, wellness and recovery environments offering a safe harbor for the crisis, and telephonic response services. Within each of these there are also service model variations that make the consistent assessment of outcomes difficult. This is particularly true in the level of care transition programs variously described as peer bridger, mentor, and coaching services. Recovery-based community support programs also encompass diverse forms of programs and services. Across all three of these levels of PSS, there is a clear need for better measurement and monitoring of outcomes within each of the programs. There is also a significant need for better comparative and controlled research studies that evaluate the different service models and the determining factors of successful outcomes.

Among the PSS programs observed in this study, most of the outcomes that were provided were generated from contractual reporting made to or by payers and funders. Some of the programs reported that they do not have sufficiently qualified staff to support detailed outcome monitoring or evaluation. Additionally, three of the programs reviewed (GMHCN, NYAPRS, and RI) note that the funding for their programs is limited and there has not been a commitment from funders to support these roles. The RI program has built in some accountability evaluation to meet the requirements of their accreditors.

In reviewing the measurement and reporting of outcomes, one individual at a program site commented: "The outcomes that many people outside of peer services are looking for are not consistent with what we are trying to accomplish. Peer services are trying to help people regain mastery of their life in whatever way best fits their needs." While this is a sentiment of some peer programs, the focus on supporting recovery, resilience, activation, community tenure, and improved quality of life is also consistent with reducing hospital utilization and will in turn reduce costs. Therefore, improving recovery, resilience, and activation are proximal outcomes that may in turn increase community tenure and could be instrumental in achieving the more distal outcome of reduced hospital utilization and costs. If PSS programs are provided the necessary resources and technical assistance to develop better outcome evaluations, it is likely that this can be accomplished.

A future challenge for the PSS field will be the establishment of common outcome goals and consistent measurement processes. This may be particularly challenging since there is a range of service types and intervention models. The field is further challenged by a lack of funding to support the systematic study and evaluation of performance measures and outcomes as well as staffing and programmatic models in these organizations.

Conclusions

This study has examined the role of PSS and their potential for reducing unnecessary psychiatric hospital admissions, readmissions, and avoidable ED utilization. A framework for the types of peer services that might impact these outcomes has been developed. These include crisis respite programs, level of care transition programs, and community-based recovery supports. Four peer-delivered service organizations have been examined to address the focus of this study.

The findings suggest that a principal goal of many of the PSS programs reviewed is to support recovery, rather than to specifically reduce utilization of high-cost health care services. However, all of the programs reviewed do see improved health outcomes and lower costs of services as fundamentally important. While the outcomes reported are based on limited and variable rigor and sophistication, they do yield some evidence that suggests that these PSS programs likely have significant impact toward reducing utilization of hospital and ED services.

Significant challenges to the measurement of outcomes among the PSS programs reviewed are noted. These include the lack of structured service models, funding models that do not support staffing and administrative resources to effectively measure outcomes, and limitations in the integration of peer services within overall health systems that complicate the evaluation of the effectiveness of these services. More rigorous and systematic evaluation research of PSS is needed and can help document the promising findings reported in this study.

There is promise for the continued expansion of PSS and their integration across the full spectrum of health care. Recipients of these services report favorable experiences, and PSS providers and managed behavioral health care organizations report very promising results. Additional systematic evaluation research is needed to verify these findings and shed light on other issues related to the role of peer services in health care service delivery.

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APPENDIX A. NATIONAL EXPERT PANEL

Name	Organization
Allen Doederlein	President Depression & Bipolar Support Alliance
Larry Fricks	Director Appalachian Consulting Group Deputy Director SAMHSA-HSRA Center for Integrated Health Solutions (operated by the National Council for Behavioral Health)
Pamela Greenberg, M.P.P.	President & C.E.O. Association for Behavioral Health & Wellness
Tanya Stevens	Deputy Director New York Association of Psychiatric Rehabilitation Services

APPENDIX B. KEY INFORMANTS

Lori Aschraft, Ph.D.
Executive Director
Recovery Opportunity Center

Sue Bergeson
National Vice President, Consumer &
    Family Affairs
Optum Behavioral Health

Matthew Chinman, Ph.D.
Behavioral Scientist
RAND

Larry Davidson, Ph.D.
Professor of Psychiatry
Yale School of Medicine

Lisa Goodale
Vice President of Training
DBSA

Steve Harrington
Executive Director
iNAPS

Sherry Jenkins Tucker
Executive Director
GMHCN

Tom Lane
National Director of Consumer & Recovery
    Services
Magellan Health

Steve Miccio
Chief Executive Officer
PEOPLe, Inc.

David Miller, MPAff
Project Director
National Association of State Mental Health
    Program Directors

Dan O'Brien-Mazza, M.S.
National Director, Peer Support Services
VA

Joseph Rogers
Chief Advocacy Officer
MHASP

Tanya Stevens
Director of Peer Services Division
NYAPRS

Pamela Greenberg, M.P.P., & Various Member
    Companies
President & CEO
ABHW

APPENDIX C. PEER SUPPORT SERVICES PROGRAMS -- BRIEF CASE STUDIES

BALTIC STREET, AEH, INC.
(BALTIC STREET)

9201 4th Avenue, Fifth Floor
Brooklyn, New York 11209
Phone: (718) 833-5929
Website: http://www.balticstreet.org/

Program Overview:
Baltic Street, AEH, Inc. (Baltic Street), established in 1996, is a peer-run, not-for-profit corporation dedicated to improving the quality of life for people living with mental illness. Baltic Street offers many types of support including programs focused on supported housing, self-help, employment, and Bridger programs. All programs are recovery-oriented to help recipients obtain jobs, housing, social supports, education, vocational training, entitlements, and other life-enhancing services. The Baltic Street Bridger Programs work with mental health recipients as they move from longer term state hospital residence into the community. Bridger staff initiate contact with the client while in the hospital and maintain contact once they transition into the community. The Bridger staff also work as a team to be a "special bridge" that helps recipients go back to living in the community and develop adequate community connections.

Program Catchment Area:
Self-help and advocacy programs span the boroughs of New York City. The Bridger program focuses on the following: Kingsboro Bridger Program in Brooklyn, works with adults who are in the discharge process from Kingsboro Psychiatric Center; South Beach Bridger Program in Staten Island, works with adults who are in the discharge process from South Beach Psychiatric Center; South Beach Lodge Bridger Program in Staten Island, works with adults enrolled in the South Beach Lodge I and II Residences Programs; and Optum Bridger Program, housed in Brooklyn.

Typology of Program:	Program Model:
Transition in levels of care; and community-based care to promote recovery and resiliency.	Bridger Model, which is similar to NYAPRS.
Peer Specialist Certification:	**Medicaid:**
Program has training criteria, which includes completion of the NY Academy of Peer Support online training.[1]	PSS is not Medicaid reimbursable in New York but the state is in the process of changing this.

Program Financing:
Baltic Street has contracts with the New York OMH and a managed care company, Optum Health. The contracts are deliverables based (number of clients worked with per month, etc.). The program is designated as a safety net provider. Funding is up to $5 million annually.

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[1] See
http://www.academyofpeerservices.org/pluginfile.php/3101/mod_resource/content/1/APS%20Webinar%20Rev.3.5.14.pdf.

BALTIC STREET (*continued*)
Data and Outcome: All Baltic Street programs collect the following information: number of staff hours, number of people served, the types of needs reported by individuals transitioning from state hospitals. Optum Health has access to information regarding hospitalization stays for their clients.
Service Recipients: Baltic Street serves 5,000 individuals annually across programs. Most clients have mental health or co-occurring mental and substance use conditions. The self-help and advocacy programs serve clients regardless of referral source. The Bridger Program serves clients who are being discharged from specific state hospitals. The Housing program serves clients from any referral source, but is currently full with a waiting list. A recent contract includes working with forensic clients, which does not allow for as much freedom of choice as PSS usually emphasizes.
Staff: Of the 100 staff members, 90 are peers. All staff complete online training offered by the NY Academy of Peer Services.[2] The online training covers WRAP, motivational interviewing, trauma-informed care, among other skills.
Site Contact: Isaac Brown   Chief Executive Officer   ibrown@balticstreet.org

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[2] See http://www.academyofpeerservices.org/.

GEORGIA MENTAL HEALTH CONSUMER NETWORK, INC. (GMHCN) PEER SUPPORT, WELLNESS AND RESPITE CENTERS

246 Sycamore Street
Decatur, Georgia 30030
Phone: (800) 297-6146
Website: http://www.gmhcn.org/

Program Overview:
The Georgia Mental Health Consumer Network (GMHCN) is a non-profit corporation founded in 1991 by consumers of state services for mental health, developmental disabilities, and addictive diseases. While the GMHCN has a number of impressive peer-based programs, our discussion focused on their well-established Peer Support Wellness Center (PSWC). PSWCs are peer-run alternatives to a traditional mental health day program and psychiatric hospitalization and include a limited number of respite beds for those that are in crisis. PSWCs began in Decatur, Georgia in 2007. Two more PSWCs were opened in 2010 (Cleveland and Cartersville), and additional sites were started last year (Moultrie and McDonough). Each PSWC hosts daily wellness activities, a 24-hour warm telephone line, and 3 bedrooms for respite guests who receive 24 hour/day care for up to 7 days.

Program Catchment Area:
Five PSWCs across the State of Georgia in the cities of Decatur, Cleveland, Cartersville, Moultrie, and McDonough.

Typology of Program:	Program Model:
Crisis and respite services.	IPS services.

Peer Specialist Certification:	Medicaid:
Certified peer specialists are required to meet state standards and provider standards. 80 hours of training are required and 12 hours of Continuing Education Credits are required annually to retain certification.	PSS is Medicaid reimbursable in Georgia.

Program Financing:
The PSWCs are run by the GMHCN in partnership with, and funded through, a grant contract with Division of Mental Health, Developmental Disabilities and Addictive Diseases of the Georgia Department of Human Resources. Their contract with the state requires that certain deliverables are met. Example deliverables include items such as: an average number of 2 respite beds are filled per day; an average of 10 calls are received at the call center per day; and an average of 5 participants participate in daily programming.

Data and Outcome:
A Recovery Oriented Systems of Care survey is presented to each individual during their stay. The survey is also presented to all daily participants during the final week of each month. The form is anonymous and voluntary, and the results are submitted for data analysis twice a year. No hospitalization records are collected or reported. The site also reports to the state the number of participants/service recipients who engage in the center's activities each month.

Service Recipients:
Individuals must be at least 18 years of age and self-identify as a person who is a consumer of mental health services. They must also have a house tour and sign Participation Guidelines before engaging in Center activities. There are no per-person costs that are billed to any payer. Respite guests must complete a "proactive interview" to determine suitability to stay at the Center and to begin developing a relationship. All individuals are self-referred and welcomed regardless of insurance status. No insurance information is requested.

GMHCN (*continued*)
Staff: There are 7 certified peer specialists employed at each of the 5 PSWC centers. All are trained to work with peers with mental health conditions and have received first aid, CPR, and WHAM training to be whole health coaches. Some are additionally trained to work with addictions conditions. There are no clinical staff at the centers.
Site Contact: Sherry Jenkins Tucker   Executive Director   sjtucker@gmhcn.org

HOUSING OPTIONS MADE EASY, INC.
(HOUSING OPTIONS)

75 Jamestown Street
Gowanda, New York 14070
Phone: (716) 532-5508
Website: http://www.housingoptions.org/

Program Overview:

Housing Options Made Easy (Housing Options) is a 501(c)(3) not-for-profit supported housing and community support services agency, developed and operated by and for recipients of mental health services. The program began in 1990 and seeks to help individuals facing mental health challenges to find affordable housing and jobs, and to explore educational opportunities. The program provides individuals with an alternative to homelessness, crisis, and hospitalization. Housing Options operates over 400 units of Section 8 housing in Western New York. Units are leased by Housing Options. In their programs in Monroe County, they have Peer Specialists work with individuals who have been in long-term state psychiatric hospitals and transition them to community housing. Housing Options also provides non-housing related community-based services programs, an employment and resiliency program aimed at transition-aged youth with behavioral health conditions, and STRAWW. STRAWW is a partnership project with other community support agencies. Two warm lines received over 4,000 phone calls last year.

Program Catchment Area:

Housing Options serves 6 New York State counties: Erie, Cattaraugus, Chautauqua, Allegany, Niagara, and Monroe.

Typology of Program:	Program Model:
Transition in levels of care; and community-based care to promote recovery and resiliency.	Program uses a supported housing model but revises the model to include a recovery focus and peer specialist involvement.
Peer Specialist Certification:	**Medicaid:**
New York State OMH is developing a peer specialist certification process in conjunction with peer leaders.	PSS is not Medicaid reimbursable in New York.

Program Financing:

The various programs are funded through contracts from the New York OMH, Office of County Mental Health, and Optum Health (managed care company). Housing Options also receives federal funding for housing. Since PSS is not covered under Medicaid within New York, there are no uniform rates for PSS. Contracts are performance based. Total funding exceeds $6 million/year.

Data and Outcome:

The program collects information from clients through surveys at intake and throughout the year. Self-report outcomes of interest include hospitalizations. A case management software program is used to track peer specialist contact with clients and what occurs at each contact. Some specific outcomes include: 90% of their clients do not seek hospitalization for psychiatric problems. Annual recipient surveys for the past 10 years have shown that 90% or more have less need for crisis intervention. In their program for transitioning individuals from long-term state hospitals into the community, more than 70% of the individuals have remained in the community for over 1 year. They estimate that cost savings from this transition program exceed $12 million annually.

HOUSING OPTIONS (*continued*)

Service Recipients:

Individuals are referred to Housing Options through a number of sources including managed care companies, community mental health centers, and other community support providers. Within the Supported Housing program, peer specialist work with clients to find out where they want to live and provide them with options for apartments, furnishing, and provide support that meets the needs of the client. Clients have a mental health or co-occurring mental health and substance use conditions. In the non-Supported Housing programs, clients work with peer specialist to identify employment and educational activities. The focus is on working with individuals to "ignite" the spark of life.

Staff:

There are 70 peer specialist staff members. All staff go through training provided by Housing Options and are supervised by a regional manager and training coordinator. In addition to traditional PSS training, peer specialists are trained in safety and risk management, note taking, and community support resources, among other items.

Site Contact:

Joe Woodward
Executive Director
joe@housingoptions.org

MENTAL HEALTH ASSOCIATION OF SOUTHEAST PENNSYLVANIA (MHASP)	
1211 Chestnut Street, Room 1100 **Philadelphia, Pennsylvania 19107** **Phone: (215) 751-1800; (800) 688-4226** **Website: http://www.mhasp.org/**	*The Bell of Hope* MENTAL HEALTH ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA

Program Overview:

Mental Health Association of Southeast Pennsylvania (MHASP) is a non-profit corporation that is headquartered in Philadelphia, Pennsylvania. MHASP maintains an additional 4 satellite locations in 4 counties that offer PSS. MHASP programs are mostly community-based and focus on 5 domains: advocacy, direct support to individuals, training and education, information and referral, and technical assistance. Its programs include Peer Support Teams, a Self-Directed Care Project, and Recovery and Education Centers. This case study focuses on their community Self-Directed Care Project and other similar community-based services provided in the state since the data collection is more robust for those programs. Generally, clients receive Medicaid and are referred to services. A fee-for-service model is used and Peer Specialists (PS) work with clients in the community or in a client's home. Program staff often work closely with traditional case managers to coordinate services.

Program Catchment Area:

Throughout Bucks, Chester, Delaware, Montgomery and Philadelphia counties.

Typology of Program: Community-based to promote recovery and resiliency.	**Program Model:** Program developed organically. No specific model was adopted. Currently working with Temple University to manualize their peer-delivered self-directed care program.
Peer Specialist Certification: Certified Peer Specialists have lived experience and must complete 2 weeks of training and pass an exam. There are yearly continuing education units and opportunities for additional trainings.	**Medicaid:** PSS is Medicaid reimbursable in Pennsylvania.

Program Financing:

MHASP uses a fee-for-service payment model. All clients have Medicaid coverage and are referred to MHASP for services. MHASP receives reimbursement from the state and from 3 managed care companies: Magellan, CBH, and CCBH. Peer specialists maintain electronic health records.

Data and Outcome:

Since MHASP maintains electronic health records, client contact data and self-report client data are available. In the past 5 years, the Delaware County site has worked with Temple University to conduct research looking at use of county reinvestment dollars for self-directed consumer care, compared with usual care. While the study has not yet been published, there are a lot of data on individuals who engaged in the program. Unfortunately, the study did not specifically focus on hospitalization, although it is possible there is some information about hospitalization rates in the data.

Service Recipients:

Service recipients have a mental health, or co-occurring mental health and substance use conditions. All clients are Medicaid recipients and are referred for services. Referrals come from managed care companies, community providers, and hospitals, among other sources. Services are provided on a time-limited basis within the community or in the client's residence. The program generally maintains a 1:25 peer specialist to client ratio.

MHASP (*continued*)
Staff: All program staff must complete the MHASP training. All peer specialists are WRAP certified. Some staff are specially trained to work with individuals with SUD. Staff generally work in the field (not an office setting). There is a separate training track for staff that only want to work with individuals in recovery from substance use problems.
Site Contact: Joe Rogers Chief Advocacy Officer jrogers@mhasp.org

NEW YORK ASSOCIATION OF PSYCHIATRIC REHABILITATION SERVICES, INC. (NYAPRS) PEER SERVICES

194 Washington Avenue, Suite 400
Albany, New York 12210
Phone: (518) 436-0008
Website: http://www.nyaprs.org/peer-services/

Program Overview:
Since 1994, the New York Association of Psychiatric Rehabilitation Services (NYAPRS) Peer Bridger Program has helped individuals transition from New York State psychiatric centers into community life. The Peer Bridger Project employs Peer Bridgers, persons who have been successfully managing their own recovery from a psychiatric disability and have completed the requisite Peer Bridger Training Program offered by NYAPRS. Recently, NYAPRS has also begun work under contracts with managed care companies Optum Health (since 2010) and Healthfirst (since 2014). In collaboration with the managed care companies, NYAPRS had adapted the Peer Bridger Program to focus on transitioning individuals in non-state hospitals (stays up to 21 days) into the community.

Program Catchment Area:
Through their contract with New York State, NYAPRS delivers services in the following counties: Albany, Ulster, Broome, Queens, Suffolk, and Westchester. Through the managed care projects, services are delivered in Albany, Long Island, and New York City.

Typology of Program:	Program Model:
Transition in levels of care.	Peer Bridger model, based heavily on IPS model.

Peer Specialist Certification:	Medicaid:
Current peer specialist requirements include 5 days of training conducted by NYAPRS. Additional, optional training includes specialization in housing and entitlements. Once New York State sets standards, peer specialists will be required to meet state standards.	PSS is not Medicaid reimbursable in New York. However, this is in the process of changing and will affect the billing and reimbursement of these services.

Program Financing:
There are 3 funding streams for NYAPRS Peer Services. They have contracts with OMH, Optum Health, and Healthfirst. Currently, contracts do not tie funding to specific clients. However, clients are identified through referrals from the state or managed care companies. Services covered include outreach, engagement, and PSS delivery. Once Medicaid funding is available (estimated Summer 2015), there may be some changes to how services are financed.

Data and Outcome:
In 2008, the Peer Bridger Project looked at the hospital records for 176 individuals who participated in the program to transition from state hospitals into the community. These data showed that approximately 71% of the people were able to stay out of the state hospital in 2009. NYAPRS has access to and analyzes the state data at intervals. NYAPRS focuses on recovery variables, measures of outreach and engagement, and hospitalizations. Optum and Healthfirst analyze data independently of NYAPRS and look at hospitalization rates.

Service Recipients:
All clients engage in the program voluntarily and have a history of mental health and/or substance use conditions. Through the New York OMH contract, peer specialists meet with and work with clients in the state hospitals and then in the community. Through the managed care contracts, peer specialists work with telephonic case managers to identify individuals who have had 2 or more hospitalizations within 6 months. Much of the time is spent on outreach and engagement of these clients. In all programs, clients are increasingly self-referred.

NYAPRS (*continued*)
Staff: 21 Peer Specials, 7 of them part-time. All staff are trained in WRAP, recovery support, IPS, and the NYAPRS model. Most staff work remotely and communicate with NYAPRS Albany staff through email and telephone. Weekly supervision and peer specialist group meetings occur by phone.
Site Contact: Tanya Stevens Director of Peer Services Division tanyas@nyaprs.org

OPTUM, PIERCE COUNTY REGIONAL SUPPORT NETWORK

3315 South 23rd Street, Suite 210
Tacoma, Washington 98405
Phone: (253) 292-4200
Website: http://www.optumhealthpiercersn.com/portal/server.pt

Program Overview:
Optum is a UnitedHealth Group platform that focuses on population health management, care delivery and improving the clinical and operating elements of the health care system. Since 2009, Optum has served as the RSN for Pierce County, Washington. As the RSN, Optum coordinates mental health care for Medicaid beneficiaries (an eligible monthly population of approximately 135,500) through a network of inpatient, outpatient, and residential treatment providers. Through direct contracting with providers, Optum has changed the orientation of the Pierce County mental health system to be recovery oriented and staffed by a growing portion of Certified Peer Counselors (a.k.a., Peer Specialists) who work alongside of traditional mental health providers. Within the RSN, peers work in ED settings, in crisis centers, and in outpatient provider settings. Peers work with adults, youths, and families. Of particular interest to our study is their crisis stabilization unit, where 50% of the staff are peers, and which receives 220 referrals a month. Also of interest are their mobile crisis unit and living room program.

Program Catchment Area:
Pierce County, Washington.

Typology of Program:	*Program Model:*
Crisis and respite services; transition in levels of care; and community-based to promote recovery and resiliency.	Optum model.

Peer Specialist Certification:	*Medicaid:*
Optum conducts its own training that meet Washington State certification standards. Optum is 1 of 3 training facilities within the state. Forty hours of training are required, as well as continuing education credits.	Yes.

Program Financing:
Optum is contracted by the State of Washington. They received $85 million in Medicaid dollars, $15 million in state funding; and additional funds through the federal mental health block grant. Optum uses these funds to contract with providers in Pierce County. Optum develops detailed description of the services that are being contracted for and requires that all providers employ certified peer counselors. Peer services are billed to the state, much like other providers and at the same rate. Peers must chart their contact with clients.

Data and Outcome:
Optum's integrated provider system has allowed them to collect data on hospitalization, ED use, and health care cost. Optum notes a 32% reduction in hospitalization over 3 years, amounting to $7.3 million in savings.[3]

Service Recipients:
State of Washington Medicaid beneficiaries with mental health conditions (an eligible monthly population of approximately 135,500). Optum notes that it is in the process of becoming a behavioral health organization that addresses the needs of persons with mental health and/or substance use conditions. In rare cases where the person is not a Medicaid beneficiary, providers work with the client to help them complete paperwork for their entitlements.

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[3] See https://www.optum.com/content/dam/optum/resources/whitePapers/BSPUB0119S003JV_PierceCty-WR.pdf.

OPTUM (*continued*)
Staff:
Optum notes that 248 peers are employed within their provider network. Through their training program, Optum has trained 464 peers and continues to conduct training sessions 2-3 times a year. All peers have a history of addressing mental health conditions and all are paid employees.
Site Contact:
Sue Bergeson National Vice President, Consumer and Family Affairs Susan.bergeson@optum.com

PROJECTS TO EMPOWER AND ORGANIZE THE PSYCHIATRICALLY LABELED, INC. (PEOPLe)

126 Innis Avenue
Poughkeepsie, New York 12601
Phone: (845) 452-2728
Website: http://projectstoempower.org/

Program Overview:
Projects to Empower and Organize the Psychiatrically Labeled, Inc. (PEOPLe) is a peer-run 501(c)(3) not-for-profit organization that advocates for and provides services to people living with a mental health diagnosis. The organization is 100% peer-run. PEOPLe operates a number of PSS programs including crisis lines, warm lines, Bridger programs and hospital diversion programs. The various components work together and staff work across programs. Of particular interest to our study is the Rose House. The Rose House was developed in 2001 by PEOPLe and is a peer-operated hospital diversion program designed to alleviate emotional distress in a homelike safe and secure environment. This diversion program now has 4 locations/houses. The Rose House locations offer overnight stays of up to 5 days to assist individuals to develop new skills to maintain wellness. Peer specialists (PS) called "Peer companions" are available 24 hours a day, 7 days a week to address the needs of guests as they arise. Peer specialists are the key ingredient in helping guests learn the self-help tools. Peer specialists are compassionate, understanding and empowering. Peer specialists also maintain contact and support for guests, at their request, after they finish their stay at Rose House. Participation in the program is completely voluntary and free of charge. Guests are self-referred and may come and go as they please. A professional or family member may assist this process. A guest pre-registration screening process is used to ensure the comfort of other guests as well as the appropriateness of the program.

Program Catchment Area:
Orange/Ulster Counties -- Milton, NY; Putnam County -- Carmel, NY; Dutchess County -- Poughkeepsie, NY; Warren/Washington Counties -- Hudson Falls, NY

Typology of Program:	Program Model:
Crisis and respite services.	Developed their own model based on core values of recovery and wellness.

Peer Specialist Certification:	Medicaid:
They have created their own training module, which requires 3 days of classroom training followed by immersion training by working in the house. Listening skills, motivational interviewing, WRAP, and trauma-informed care are also taught.	PSS is not Medicaid reimbursable in New York.

Program Financing:
Funding is primarily provided by the New York State OMH. The program is deficit funded, meaning PEOPLe receives quarterly payments with which to serve as many individuals as they can. In addition, Putnam County took notice of the services offered and has supplied county dollars to the program. In order to supplement these funding streams, PEOPLe raises funds through consulting services they offer to others interested in setting up similar respite-type houses in their communities.

PEOPLe (*continued*)

Data and Outcome:
Most of the data collected at the Rose Houses are self-reported by guests. Rose House staff survey guests on a daily basis to measure what activities are most utilized and effective. Most of the questions are qualitative in nature, such as, are they feeling better emotionally, mindful of their own thoughts and behaviors, or breaking internal barriers? Program efficacy is measured based on how many individuals PEOPLe is able to keep out of the hospital, specifically the ED. These data are also self-reported and collected from the individuals during follow-up interviews. The program does a 30-day callback of the diversion program participants to see if individuals have used the hospital since they left the diversion program. At the 30-day mark, nearly 100% report that they did not return to the hospital since leaving the diversion house. Recently, individuals who had used the diversion house were called back 2 years after they used the services. Approximately 90% have not needed to go to the hospital for psychiatric problems since receiving diversion services. Local estimates show that each diversion house is saving the system $4 million a year. Local area hospitals were measuring their recidivism rates to be about 25%. PEOPLe utilizes these collected data for their state reports. They have also worked with the College of St. Rose to analyze satisfaction data. Individuals who have stayed at Rose House rate it at a very high satisfaction level.

Service Recipients:
The Rose House is available to any resident of Orange, Ulster, Dutchess, and Putnam Counties ages 18 years old and over experiencing a psychiatric crisis or emotional distress. The program is strictly voluntary and guests are self-referred. A professional or family member may assist this process. A guest pre-registration screening process is used to ensure the comfort of other guests as well as the appropriateness of the program.

Staff:
There are approximately 65 peer specialists employed by Rose House. Each location is staffed 24 hours a day, 7 days a week. Each house has between 15-18 staff members assigned. Staff consists of both full-time and part-time employees, all of whom identify as peers. There are non-peer staff on-site.

Site Contact:
Steve Miccio
Chief Executive Officer
stevemiccio@projectstoempower.org

RECOVERY INNOVATIONS (RI)

2701 N. 16th Street, Suite 316
Phoenix, Arizona 85006
Phone: (602) 525-3003
Website: http://www.recoveryinnovations.org/riaz/RIHomepage.html

Program Overview:
Formerly known as META Services, RI was founded in 1990 and maintains programs throughout Maricopa County, centralized in Phoenix, Arizona. In most RI programs, Peer Specialists work in integrated teams with nurses, psychiatrists, psychologists, and social workers. All providers are RI employees. A range of services is offered based on the needs of the service recipient and include inpatient voluntary/involuntary alternative to hospitalization (Recovery Response Center West), living room programming for individuals transitioning out of inpatient care, and community PSS with supported housing and temporary community housing components. RI services are meant to provide a continuum of services that meet the diverse needs of those with SMI as they navigate their recovery journey.

Program Catchment Area:
Programs are run throughout Maricopa County, Arizona. Many are based in Phoenix.

Typology of Program:	Program Model:
Crisis and respite services; transition in levels of care; community-based to promote recovery and resiliency.	Whole Health, integrated PSS with other provider services. Other models including living room model, supported housing, and intentional peer specialist.
Peer Specialist Certification:	**Medicaid:**
RI offers 80 hours of state certified peer specialist training. An identical curriculum is also available in Louisiana and Pennsylvania. Once hired, all staff (including non-peers) must complete 40 hours of recovery oriented training.	PSS is Medicaid reimbursable in Arizona.

Program Financing:
Annual revenues of $12 million come from the State of Arizona Department of Health Services through a contract with the RBHA for Maricopa County, the Arizona Rehabilitation Services Administration, and the U.S. Department of Housing and Urban Development. The Peer Community Connections program is covered through a contract with Magellan and is open only to people who have Non-Title 19 services in the Magellan SMI Program. Non-Title 19 SMI services are behavioral health services for persons who have SMI but do not qualify for Arizona's Medicaid program (Arizona Health Care Cost Containment System). There is a children and adolescent program out of Phoenix Children's Hospital that is funded through Aetna. RI bills a flat fee-for-services to Medicaid. Most programs will serve anyone who presents themselves regardless of insurance or state residency. They do not bill third-party insurance. Peer specialists provided over $6 million in reimbursable services at RI during 2006.

Data and Outcome:
Since this is a medical facility, Level 1 Sub-Acute Health care facility and licensed by JACO, there are medical records and records of peer specialists are integrated with other provider staff. The program collects information during the intensive intake process (for the inpatient clinic), including social history and where service recipients go to live after they leave the inpatient or living room programs. The inpatient program has a 72-hour follow-up with clients. The program states that their data show that the PSS programs have saved the state over $10 million by helping people stay out of the hospital. Since the implementation of a recovery mission, hospitalizations have decreased to the current rate of 4%. In 2 other counties where RI has provided PSS training, the data show that they have reduced hospitalization rates by 25% within 6 months. (Data from 2003-2004.)

RI (*continued*)
Service Recipients: RI provides services to over 10,000 adults with SMI and substance use issues. While most programs are open to any consumer with SMI, most service recipients are Medicaid eligible or qualify for Non-Title 19 SMI services. Some family programs serve families with SMI members.
Staff: PS are integrated into service teams. Peer specialists make up 75% of RI's 40-member staff. In the inpatient Recovery Response Center there is a physician on staff at all times (24 hours/7 days a week), but this is not true for all PSS offered.
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To obtain a printed copy of this report, send the full report title and your mailing information to:

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Washington, D.C. 20201
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