

**Pillars of Peer Support – 2**

**Expanding the Role of Peer Support Services  
In Mental Health Systems of Care and Recovery**

**The Pillars of Peer Support Services Summit - 2  
The Carter Center  
Atlanta, GA  
October 18-19, 2010**

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## **Background and Introduction**

The Pillars of Peer Support initiative is designed to develop and foster the use of Medicaid funding to support Peer Support Services in state mental health systems of care. To date, there have been two phases of the project. In the first phase (see: [www.pillarsofpeersupport.org](http://www.pillarsofpeersupport.org) for the report of Pillars I Summit), states that were then currently billing Medicaid for Peer Support Services gathered to review lessons learned and to formulate twenty-five Pillars of Peer Support. These “Pillars” were determined at this Summit to be factors that, if in place, will greatly facilitate the goals of the Pillars of Peer Support initiative. These “Pillars” were well received by the field, and a second phase was designed with a goal of bringing together those states that were not currently billing Medicaid for Peer Support Services. The Summit II was designed to examine opportunities for expansion of Medicaid-billable peer-support services in these states, and to identify the assistance each participating state might need to accomplish that goal.

Both Pillars of Peer Support Summits were held at the Carter Center in Atlanta, GA, which graciously provided the meeting space. Other sponsorships that have promoted these phases of the initiative include support from: The National Association of State Mental Health Program Directors (NASMHPD); OptumHealth Public Solutions; the Georgia Mental Health Consumer Network; and the Appalachian Consulting Group. CMS representatives also participated in the summits and provided guidance and assistance to the project. Both of the Pillars of peer Support Summits were led and facilitated by Ike Powell.

The Pillars of Peer Support II Summit was held October 18 and 19, 2010. Invitations were extended to those states that did not at the time have an established mechanism to bill Medicaid for Peer Support Services. Each state was invited to send two representatives, and it was recommended that those two might include a Consumer Leader and a Medicaid representative, though ultimately each State chose people whom they thought would best represent the State’s needs. This report provides a summary of the proceedings and resources to help promote the mission of expanding Medicaid-billable Peer Support Services to all states. It is important to note that peer support occurs in a variety of forms, settings, and interactions. The focus of this report is on Peer Support Services which are formalized services that are provided by Certified Peer Specialists, or others who have received specific training and certification in this area.

This report includes summaries of the presentations that were made at the summit. These include a review of the evidence base for Peer Support Services and a review of service implementation to date in the various states. A number of panel discussions were held during the summit and summary responses from the participants are included. A final section examines the work done by the state representatives at the summit and the opportunities and challenges for implementing a state plan for Medicaid reimbursed Peer Support Services. The identified needs for technical assistance are also reviewed. Steps and opportunities are also provided to guide future work of the summit participants and sponsors.

## **Part 1- Panel Discussions**

In order to set the stage and provide a framework for the Pillars II Summit, a series of panel discussions were presented. These included brief presentations by invited subject experts, which

were followed by interactive questions with the audience. For the purpose of this summary report, the panelists were asked to provide brief responses to a series of questions in order to better capture their comments that were subsequently made at the summit.

**Joseph Rogers**

President: Policy & Advocacy Division

Mental Health Association of Southeastern Pennsylvania (MHASP)

**1) How do we ensure that peers who work in the system as providers will not be co-opted by the system?**

There will always be some degree of peers being co-opted by the system. The key is helping Peer Support Specialists to engage with the system and getting the system to incorporate them into routine operations. As Peer Support Specialists are able to become a part of a state wide movement, they will be able to build networking opportunities and foster engagement. There is an important role of advocacy in the peer support role, and there should be adequate training and job description support for these activities.

**2) How can we ensure that the peers will be supported by the agencies that hire them?**

One of the key factors is the training for the supervisors of Peer Support Specialists. The supervision of the Peer Support Specialist is different from other supervisory relationships and there needs to be established guidelines for this. States must recognize the unique needs of Peer Support Specialists and leadership for this must be established at the highest levels in the state and in the specific agencies that employ them. This commitment and the corresponding training needs must include a focus on recovery values and programs.

**3) What do we need to do to ensure that the philosophy and values of peer support are maintained and the focus is on strength-based recovery in a system that is often based on a disease-focused and medical model approach to treatment?**

This needs to be a national focus with a commitment to core values and standards of treatment that include peer support. We need to have well established definitions of peer support services, the standards and certification requirements for these roles, and advocacy for their essential role in all recovery based services. This needs to be an ongoing initiative that will require continued advocacy and work.

**4) What quality assurance measures can be built into peer support services?**

Although I am not an expert quality improvement, it is essential to build and foster quality measures across all peer services. We need to be able to document and track the goals of Peer Support Specialists and monitor the outcomes of their work. Consumer satisfaction is a key component of this.

**Pam Warner**

Michigan Department of Community Health

Bureau of Community Mental Health Services

**1) How should new states fund the recruitment, training and certification process prior to peers being hired into Medicaid billable positions?**

Need to examine a variety of funding sources. Some ideas include: Federal grants such as the funding provided by SAMHSA to states for innovations. (Michigan gets a set amount as does I believe every other state). Need to look at a variety of other grant sources including foundation grants and resources provided at [www.grants.gov](http://www.grants.gov). Other ideas are to request local funding in the state to have providers, agencies, mental health programs etc pool dollars.

## **2) How should states establish billing codes and reimbursement rates?**

Each state is different and this will depend on the type of state plan or waiver that they are operating under. If the program has a fee for service structure then the rate establishment will be used and applied in the same historical method. Michigan uses the Healthcare Common Procedure Coding System (HCPCS) codes set by CMS. After a review of all the codes the H0038 fit the peer area the best. When I was working with some states on day two another state had chosen this code to specifically use for peer services. Michigan's reimbursement rate is determined locally based on what is fair market value as part of the Managed Care and Specialty Services Waiver.

## **3) How should peer support services relate to existing services? Should they complement or replace them?**

This is confusing to me. If we really want CPSS in each state with federal funding they need to be a distinct service. However, this question appears to be more of an issue of team and partnership. In that case, peer services complement a wide array of services that are based on a foundation of recovery. Peers provide a role that other professions/disciplines do not offer which leads to a larger array of services for individuals to choose from in the person-centered planning process.

The tricky part to this question is about leadership. If I was running an agency and in a leadership position, I would look at each vacancy I have and make a decision on how to fill that and with what provider(s). Many positions I would fill with Peer Specialists. Peers would not be replacing case managers; they may however be filling positions that were redesigned to meet the needs of the populations being served. On the outside view it may appear that peers are replacing case managers but in reality it is agency change moving forward to an environment of recovery and quality outcomes. This is the real work of mental health system transformation efforts. Without a cadre of peers, agencies who expect that recovery will just "happen" are naïve.

## **4) Who decides the qualifications, competencies, job descriptions, training curriculum, testing and certification process or guidelines?**

In our state the qualifications, competencies, training, testing and certification requirements were completed by leadership in the central office, and written in the Medicaid Provider Manual including Provider Qualifications. The 1915 b(3) waiver description outlined what work would be covered under the H0038 (peer specialists) code. The description in the Medicaid provider manual is what has driven job descriptions at the local level. Job descriptions at the local level have been developed under the auspice of the state Medicaid description for peers. The local job descriptions are often written by managers, supervisors, HR departments including consumer-run organizations. Other agencies have peers develop the job description in partnership with agency

managers. This question on the development of job descriptions is fluid and will depend on the setting of where each person is employed.

I firmly believe that the central office leadership in each state must have a strong involvement and influence in these areas to set the stage for the provider organizations. When guidance is given at the state level criteria will be built in at the beginning and applied consistently across all regions.

**5) What is involved in developing a state plan amendment to include Medicaid billable Peer Support Services?**

This is the largest barrier that I learned from the Summit. It isn't about the leadership of states or the passion of people who work in the central office to get this done, it really is about CMS. Many of the states talked to me about the fear of approaching CMS to even open up the state plan by asking for an amendment. One state discussed that once this was done it could negatively affect other programs and entitlements. I completely underestimated the consequences of asking for an amendment.

Wendy would be a good resource in this area and I would ask Peggy Clark to provide some guidance and TA in this area. Maybe CMS has written information on developing state plan amendments or some other documentation that can be added to the report. I do believe that this is one of the worst times to open a waiver or ask for an amendment given the economic climate. I left the Summit on the second day with the realization that this is probably the largest barrier in providing peer services.

**6) What did you find helpful in getting the cooperation from Medicaid and others who may not fully be in favor of the program?**

What was most helpful is the leadership of state office staff. We run all of the funding and contracts out of the mental health office versus the state Medicaid agency. We work in partnership with the state Medicaid agency but the amendments and waiver conversations with CMS occur directly in this administration. My thoughts/advice on cooperation is to find a way to sell the program by peers leading the way. Finding opportunities for peers to tell their recovery stories and to have others share what working with a peer did for their health and wellness is important. One of the most important areas that requires more research is to examine the cost savings and power of peer support in transitioning "beneficiaries" out of services and supports. Managed care is about savings and the number of eligibles covered. Cooperation is going to be based on financial savings for the next few years as it will be driven by the economy.

The other important thoughts I have had recently is that we need to closely monitor health care reform and the upcoming legislative changes to look for the avenues and areas of opportunity to fit in funding and coverage for peer support. I believe the area of peer led health and wellness will be a great opportunity to move forward in maintaining and enhancing coverage.

**Sherry Jenkins Tucker**  
Executive Director

**1) What are the various services that CPSs can provide that are Medicaid billable?**

Peer Support Services, Assertive Community Treatment and Community Support Individual in the state of Georgia.

**2. Is there value in having Medicaid billable peer support services and non-Medicaid billable peer support services such as Drop-in Centers operating in the same state?**

Yes it is very important to have both. Medicaid is quite rigid and inflexible with regard to what can be provided and reimbursed. Peer support services that are not Medicaid billable can have more flexibility. We are able to offer Certified Peer Specialists (CPSs) who provide peer support around Double Trouble in Recovery meetings, we provide Peer Mentors who are CPSs and support peers with transitioning out of State Regional Hospitals and into communities and lives of meaning and purpose, CPSs run the Peer Support and Wellness Center and provide peer support during daily wellness activities, and 24/7 over the phone and supporting people who are staying in respite beds. Are they complementary or in conflict/competitive? I think they can be seen as complementary and in some cases as alternatives.

**3. We currently have trained and certified Peer Specialists who are working throughout the state, but are not Medicaid billable. Why should we make the shift?**

You can bring more resources into your state through the Medicaid match and thus have more resources in the mental health system in general.

**4) What would be involved in consumer run organizations being able to bill Medicaid?**

They would need to go through the process of becoming a Medicaid provider in the state in question, the process varies from state to state.

**Wendy White Tiegreen, MSW**

Director, Medicaid Coordination

Georgia Department of Health and Developmental Disabilities

***Peer Support and Whole Health***

There is an emerging trend in Peer Support Services to bridge the gap between physical and behavioral health. As health systems move toward greater recognition of the importance of integrating physical and behavioral health, a person-centered approach to health is vital. This has come to be known as the whole health approach. In the panel discussions, Wendy White Tiegreen, MSW outlined many of the important issues for Peer Support Whole Health.

**1) How might the Patient Protection and Affordable Care Act change/impact the work and role of Certified Peer Specialists?**

The PPACA outlines many provisions for Primary Health and Behavioral Health integration; despite this vision set forth in law, these have historically been very separate and distinct systems. In order to realize the vision of health integration, we have to build bridges between these separate systems and then work to shorten those long bridges as there are more combined elements of work. And here is the real opportunity for Certified Peer Specialists: if CPSs can be trained in health and wellness coaching, as they are in Georgia, then they have a unique role in

having the trust of the person who is trying to manage his/her own mental health issues and having the skill set to be the bridge to the health community, whether it be to Federally Qualified Health Centers or to private physicians, or any health support in between.

**2) What would be the benefit of CPSs doing this work versus other types of professionals?**

CPSs are in the unique position of having the lived experience of mental illness management and personally know the factors which helped assist recovery. Then, building on this unique experience, they acquire skills which enable them to elicit goals, objectives and desires from the individual. They also are trained to develop skills which assist the served individual in developing skills to build wellness and recovery. Specific to health integration, CPSs may uniquely have the experience to coach individuals to express their own health needs, to encourage these supported individuals to talk about and elicit assistance for symptoms which are challenging, and to advocate from a “peer” perspective. The primary health system can be daunting and full of information which is in “professional-ese.” Individuals who are already struggling with a mental illness can be supported to navigate this system and move toward wellness.

**3) What are the qualifications that CPSs might need to be the type of “bridge” you mention?**

There are several elements to peer-supported health and wellness. The skills of CPSs can include but aren’t limited to:

- the importance of good nutrition to their mental and physical health,
- how to purchase nutritious food on a limited budget,
- how to address modifiable health risk factors such as obesity and diabetes,
- how to self-identify and self-monitor health issues,
- how to set health goals while also managing mental health,
- supporting a person’s practicing of the articulation of personal health needs and goals so that these needs are known and addressed, and
- how to encourage a person’s follow-up and ultimate self-management of his/her health.

**Part 2 - Research Findings for Peer Support Services**

The summit also featured two presentations on the evidence base for peer support (Allen Daniels) and a NASMHPD survey of the states’ use of peer support services (Ellie Shea-Delaney from Massachusetts).

**The Evidence Base for Peer Support**

The evidence based review for peer support services examined the literature and range of research for these services. The scope of peer support services has continued to expand over the recent years. Estimates suggest that groups, programs, and organizations run by and for people with serious mental illness and their families outnumber professionally run mental health organizations by a ratio of almost 2 to 1 (Lucksted et al. *Psychiatric Services* 60:250-253, February 2009). Yet, the evidence base for peer-provided services remains small (Woodhouse and Vincent 2006). The effects of peer services have not been rigorously assessed and the limited randomized or controlled trials and other comparative studies contain evidence about both positive and negative effects of involving peers in the delivery and evaluation of mental

health services. (Simpson, House: *BMJ* 2002;325;1265). And, although reasonable evidence supports the efficacy of structured self-management programs for chronic physical conditions such as diabetes and asthma, far less research has evaluated this approach for mental disorders. (Cook et al. *Psych Services* 60:246-249, February 2009).

A national survey of over 250 Certified Peer Specialists, reviewed their roles and activities (Salzer, et al. *Psychiatric Services* 61:520–523, 2010). The study found that Peer Support Specialists work in a variety of settings and roles (see Table 1).

Table 1

<b>Where PSS Work - Program Type</b>	<b>Respondents = 257</b>
Independent Peer Support Program	62
Case Management	50
Partial Hospitalization or Day Program, Inpatient, or Crisis	28
Vocational Rehabilitation of Clubhouse	21
Drop-in Center	20
Therapeutic Recreation of Psychiatric Rehabilitation	7
Residential	10
Education and Advocacy	15
Other or Unable to Code	44

The Study also examined the frequency and level of peer support activities. For reporting these were divided into high and lower level activities. See Table 2 and 3.

Table 2

<b>Peer Support Activities -Higher Frequency</b>	<b>5 = Always 1 = Never</b>
Peer Support	4.48
Encouragement of Self-Determination and Personal Responsibility	4.26
Support Health and Wellness	3.87
Addressing Hopelessness	3.84
Communication with Providers	3.6
Illness Management	3.62
Addressing Stigma in the Community	3.56
Developing Friendships	3.51
Leisure and Recreation	3.25
Education	3.16
Transportation	3.06

Developing WRAP Plans	3.04
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Table 3

<b>Peer Support Activities Lower Frequency</b>	<b>5 = Always 1 = Never</b>
Family Relationships	2.95
Employment	2.94
Citizenship	2.83
Spirituality and Religion	2.74
Developing Psychiatric Advance Directives	2.27
Parenting	2.14
Dating	1.74

The findings support that there are active roles for peer support services, and Peer Support Specialists are active in a variety of settings and activities. Three primary forms of peer support have been described (Davidson and Chinman, 2006). These include: naturally occurring peer support groups; consumer run services; and the employment of consumers as providers within clinical and rehabilitative settings. Four broad models of peer support have also been reported (Woodhouse and Vincent, 2006). These include: user run drop-in services; formalized specialist roles; training programs for peer specialists; and peer education.

The evaluation of peer support services is limited by a number of challenges. These include: the low numbers of participants in studies; randomization of participants is difficult and sometime unethical; the outcomes of peer services require long term longitudinal follow up; outcomes that are often difficult to define and there are unclear targets for measurement; measurements that require both quantitative and qualitative methods; and scarce financial supports for peer services research. The combination of the different roles and settings where peers provide services and the challenges for research confound the evidence base for these services.

A review of the principal service domains provides a framework to evaluate the evidence base for peer services. These domains include:

1. Outcomes of Consumer as Provider (CP) Services
2. Peer Led Recovery Model Interventions
3. Consumer Run Organizations
4. Peers as Mutual Support
5. Peer Support in Medical Care

A brief review of some representative outcome studies for these domains is included in tables 4 – 8. These are not intended as a comprehensive review of the literature, but rather examples of the types of studies for each domain. Overall the results suggest that peer support services have a positive impact in the lives of those that receive this care, and help foster recovery and promote resiliency.

Table 4

**Outcomes of Consumer Provided Services**

Study Design	Outcome	Reference
Randomly assigned patients with SMI to a case management team either made of all CPs or all non-consumers	Found CP's as effective on a variety of standardized measures of functioning and symptoms over a 2-year period	Solomon P, Draine J. 1995
Randomly assigned patients to one of three types of case management teams: traditional, client-focused (e.g., consistent with recovery), and client focused with a CP	Found no differences after 12 months between any of the groups on functioning, disability, quality of life, and family burden	O'Donnell M, Parker G, Oct 1999
Randomly assigned patients to one of two types of assertive community treatment (ACT) teams: all CP or all non-CP case managers	Although both groups spent a similar amount of time on case management activities, patients of CPs did have fewer hospitalizations and longer community tenure between them. However, there were no differences on arrests, ER use, or homelessness	Clarke GN, Herinckx HA, Kinney RF, et al.. Sep 2000
Assessed patient outcomes of three teams: (1) intensive case management with CPs as an adjunct; (2) intensive case management plus a non-consumer assistant; or (3) intensive case management without any assistants	Individuals of the CP team had greater gains in quality of life, self-image, outlook, and social support and fewer major life problems than those on the other two teams.	Felton CJ, Stastny P, Shern DL, et al.. Oct 1995
Compared patient outcomes of two teams: standard case management and a similar team with a CP.	Patients in the CP group had fewer inpatient days, improved social functioning, and some improvements in quality of life.	Klein AR, Cnaan RA, Whitecraft J. 1998

**Table 5**  
**Peer Led Recovery Model Interventions**

Study Design	Outcome	Reference
Participants were depressed patients with continued symptoms or functional impairment treated at one of the three outpatient mental health clinics. Participants were partnered with another patient, provided with basic communication skills training, and asked to call their partner at least once a week using a telephone platform that recorded call initiation, frequency and duration. Depression symptoms, quality of life, disability, self-efficacy, overall mental and physical health and qualitative feedback were collected at enrolment, 6 weeks and 12 weeks.	32 participants (59.3%) completed the intervention. Participants completing the study averaged 10.3 calls, with a mean call length of 26.8 min. The mean change in BDI-II score from baseline to study completion was -4.2 (p<0.02). Measures of disability, quality of life and psychological health also improved. Qualitative assessments indicated that participants found meaning and support through interactions with their partners. <b>DISCUSSION:</b> Telephone-based mutual peer support is a feasible and acceptable adjunct to specialty depression care.	<a href="#">Travis J, Roeder K, Walters H, Piette J, Heisler M, Ganoczy D, Valenstein M, Pfeiffer P.</a> Telephone-based mutual peer support for depression: a pilot study. <i>Chronic Illn.</i> 2010 Sep;6(3):183-91
Randomized controlled trial evaluated the effectiveness of a bi-weekly, 12-session, family-led mutual support group for Chinese caregivers of schizophrenia sufferers over 6 months compared with standard psychiatric care. Conducted with 76 families of outpatients with schizophrenia in Hong Kong and were assigned randomly to either a mutual support group or standard care.	One-week and 12-month post-intervention were compared between groups. Results indicated that the mutual support group experienced significantly greater improvements in families' burden, functioning and number of support persons and length of patients' re-hospitalizations post-tests. The findings provide evidence that mutual support groups can be an effective family-initiated, community-based intervention for Chinese schizophrenia sufferers.	<a href="#">Chien WT, Thompson DR, Norman I.</a> Evaluation of a peer-led mutual support group for Chinese families of people with schizophrenia. <i>Am J Community Psychol.</i> 2008 Sep;42(1-2):122-34.

**Table 6**  
**Consumer Run Organizations**

Study Design	Outcome	Reference
Study evaluated the impacts of participation in mental health Consumer/Survivor Initiatives (CSIs), organizations run by and for people with mental illness. A nonequivalent comparison group design was used to compare three groups of participants: (a) those who were continually active in CSIs over a 36-month period (n = 25); (b) those who had been active in CSIs at 9- and 18-month follow-up periods, but who were no longer active at 36 months (n = 35); and (c) a comparison group of participants who were never active in CSIs (n = 42). Data were gathered at baseline, 9-, 18-, and 36-month follow-ups.	The three groups were comparable at baseline on a wide range of demographic variables, self-reported psychiatric diagnosis, service use, and outcome measures. At 36 months, the continually active participants scored significantly higher than the other two groups of participants on community integration, quality of life (daily living activities), and instrumental role involvement, and significantly lower on symptom distress.	<b>Philip T. Yanos, Ph.D., Louis H. Primavera, Ph.D. and Edward L. Knight, Ph.D.</b> Consumer-Run Service Participation, Recovery of Social Functioning, and the Mediating Role of Psychological Factors <i>Psychiatr Serv</i> 52:493-500, April 2001
New clients seeking community mental health agency (CMHA) services was randomly assigned to regular CMHA services or to combined Self-help agencies (SHA-CMHA) services at five proximally located pairs of SHA drop-in centers and county CMHAs. Clients (N=505) were assessed at baseline and at one, three, and eight months on five recovery-focused outcome measures: personal empowerment, self-efficacy, social integration, hope, and psychological functioning.	Overall results indicated that combined SHA-CMHA services were significantly better able to promote recovery of client-members than CMHA services alone.	<b>Segal SP, Silverman CJ, Temkin TL. Self-help and community mental health agency outcomes: a recovery-focused randomized controlled trial.</b> <i>Psychiatr Serv.</i> 2010 Sep;61(9):905-10.

**Table 7**  
**Peers as Mutual Support**

Study Design	Outcome	Reference
Participants were depressed patients with continued symptoms or functional impairment treated at one of the three outpatient mental health clinics. Participants were partnered with another patient, provided with basic communication skills training, and asked to call their partner at least once a week using a telephone platform that recorded call initiation, frequency and duration. Depression symptoms, quality of life, disability, self-efficacy, overall mental and physical health and qualitative feedback were collected at enrolment, 6 weeks and 12 weeks.	32 participants (59.3%) completed the intervention. Participants completing the study averaged 10.3 calls, with a mean call length of 26.8 min. The mean change in BDI-II score from baseline to study completion was -4.2 (p<0.02). Measures of disability, quality of life and psychological health also improved. Qualitative assessments indicated that participants found meaning and support through interactions with their partners. <b>DISCUSSION:</b> Telephone-based mutual peer support is a feasible and acceptable adjunct to specialty depression care.	<b>Travis J, Roeder K, Walters H, Piette J, Heisler M, Ganoczy D, Valenstein M, Pfeiffer P.</b> Telephone-based mutual peer support for depression: a pilot study. <i>Chronic Illn.</i> 2010 Sep;6(3):183-91
Randomized controlled trial evaluated the effectiveness of a bi-weekly, 12-session, family-led mutual support group for Chinese caregivers of schizophrenia sufferers over 6 months compared with standard psychiatric care. Conducted with 76 families of outpatients with schizophrenia in Hong Kong and were assigned randomly to either a mutual support group or standard care.	One-week and 12-month post-intervention were compared between groups. Results indicated that the mutual support group experienced significantly greater improvements in families' burden, functioning and number of support persons and length of patients' re-hospitalizations post-tests. The findings provide evidence that mutual support groups can be an effective family-initiated, community-based intervention for Chinese schizophrenia sufferers.	<b>Chien WT, Thompson DR, Norman I.</b> Evaluation of a peer-led mutual support group for Chinese families of people with schizophrenia. <i>Am J Community Psychol.</i> 2008 Sep;42(1-2):122-34.

Table 8  
Peers in Medical Settings

Study Design	Outcome	Reference
A total of 345 adults with type 2 diabetes but no criteria for high A1C were randomized to a usual-care control group or 6-week community-based, peer-led <u>diabetes self-management program</u> (DSMP). Randomized participants were compared at 6 months.	<b>RESULTS:</b> At 6 months, DSMP participants did not demonstrate improvements in A1C as compared with controls but baseline A1C was much lower than in similar trials. Participants had significant improvements in depression, symptoms of hypoglycemia, communication with physicians, healthy eating, and reading food labels. They also had significant improvements in patient activation and self-efficacy. At 12 months, DSMP intervention participants continued to demonstrate improvements in depression, communication with physicians, healthy eating, patient activation, and self-efficacy. There were no significant changes in utilization measures .	<a href="#">Lorig K, Ritter PL, Villa FJ, Armas J. 2009</a>
Study conducted a pre- and post-program evaluation of a 7-week facilitated breast cancer peer support program in a cancer support house.	The key themes emerging from the pre and post program focus groups included: The need for mutual identification; Post-treatment isolation; Help with moving on; The impact of hair loss; Consolidation of information; Enablement/empowerment; The importance of the cancer survivor; Mutual sharing.	<a href="#">Power S, Hegarty J. 2010</a>
Study examined enablers and barriers to peer support participation and model preferences among people with colorectal cancer.	Participants demonstrated enthusiasm for peer support. Feeling unwell and worry about accessing toilet facilities were main barriers, while accessing information about treatment side effects and making treatment decisions were main positive features. Both models (telephone and in-person) were acceptable to participants with high satisfaction rates reported and findings suggested that the two models catered to different peer support needs.	<a href="#">Ieropoli SC, White VM, Jefford M, Akkerman D. 2010</a>

### **Research Findings and Conclusions**

This brief survey of the research on consumers working in peer support roles identifies different issues for the various roles in which they are engaged. The challenges of studying peer support roles present significant opportunities for further research and investigation. The following review of each of these study domains provides challenges and opportunities for future work:

- Outcomes of Consumer-as-Provider (CP) Services - When Peer Support Services are a part of ongoing treatment services and teams, favorable outcomes are noted. This requires further exploration about the evidence base for what is best practice in this area.
- Peer Led Recovery Model Interventions - There are effective models/tools that support recovery. There has not been much comparative effectiveness research across models and the models are not systematically developed.
- Consumer Run Organizations – Evidence suggests that successful outcomes are generated by consumer run organizations. Again, the structure and models of care are not well established. A future challenge is to demonstrate the role of consumer run organizations in the full continuum of clinical services.

- Peers as Mutual Support – Mutual support is successful in promoting recovery for both parties. However, this approach is not a consistent intervention model. There are also questions about how to best deploy this approach in standard care.
- Peer Support in Medical Care - Peer Support is effective and well deployed in other medical fields. This has not been as well tested in mental health, and further research is needed to build the evidence base for these services.

### **NASMHPD Peer Support Survey**

The National Association of State Mental Health Program Directors' (NASMHPD) Financing and Medicaid Division conducted a nationwide survey on the use of Medicaid to reimburse for peer support services. The goal of the study was to identify how States have designed their peer support services programs, and to share this information among the States. The survey focused on three broad categories: the authority to receive Medicaid reimbursement of peer services; the types of services, settings and payment rates for peer services; and qualifications and training for Peer Specialists.

The survey, consisting of quantitative and qualitative questions, was administered from October 1 to 14, 2010 using a web-based portal (SurveyMonkey™). Data was collected from 43 States and the District of Columbia, and presented at the Pillars of Peer Support Services Summit II held October 18-19, 2010 (PowerPoint accessible at <http://www.nasmhpd.org/PeerSupportServicesSurvey.cfm>). The survey was pretested in Georgia, Massachusetts, Michigan and Tennessee. The study found that half the states (22) surveyed have Medicaid reimbursement for peer support services. Of the twenty-one states and the District of Columbia that do not have Medicaid reimbursable peer support services, eight (Alabama, California, District of Columbia, Florida, Louisiana, Maryland and New York) plan to seek reimbursement within the next year. Out of the fourteen states not seeking reimbursement, three states (New Hampshire, Delaware, and Arkansas) commented that they are looking into adding this service, but not within the next year.

#### Authority for Medicaid Reimbursement of Peer Services

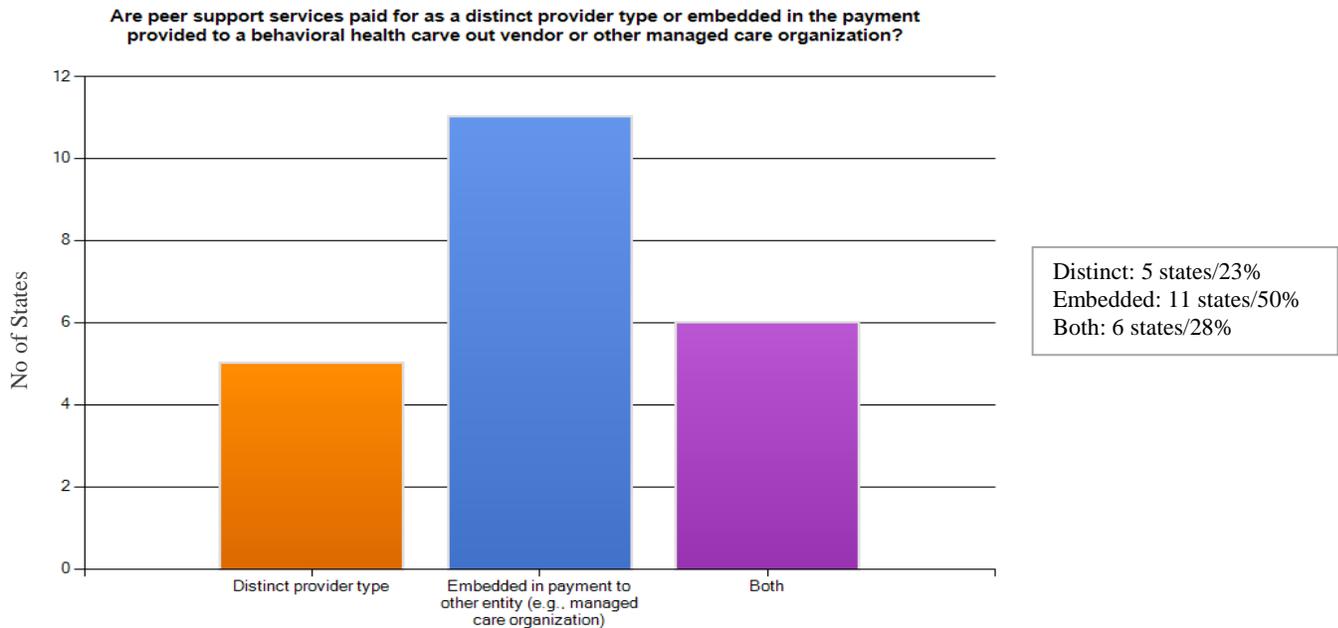
Of twenty-two state responses that now have Medicaid reimbursement for peer services, eleven states (50%) indicated that peer services were embedded in payment to other entity (e.g., managed care organizations, behavioral health carve out vendors), five states (23%) received Medicaid reimbursement for peer services as a distinct provider type, and six states (28%) had both payment arrangements (Figure 1). In response to the question, "Under what Medicaid authority are services covered?," thirteen states (59%) identified state plan, four states (18%) selected waiver, and five states (23%) indicated both (Figure 2).

Of the thirteen states that selected state plan, 12 states (92%) reported that services are covered under the Medicaid rehabilitation option [1905(a)(13)], and one state (8%) selected 1915(i). In those states where peer services included waivers, two states (50%) selected 1915(b), one state (25%) selected 1115, and one state (25%) indicated other, adding "Money Follows the Person and Community Based Services." For the five states that selected both, all five reported services

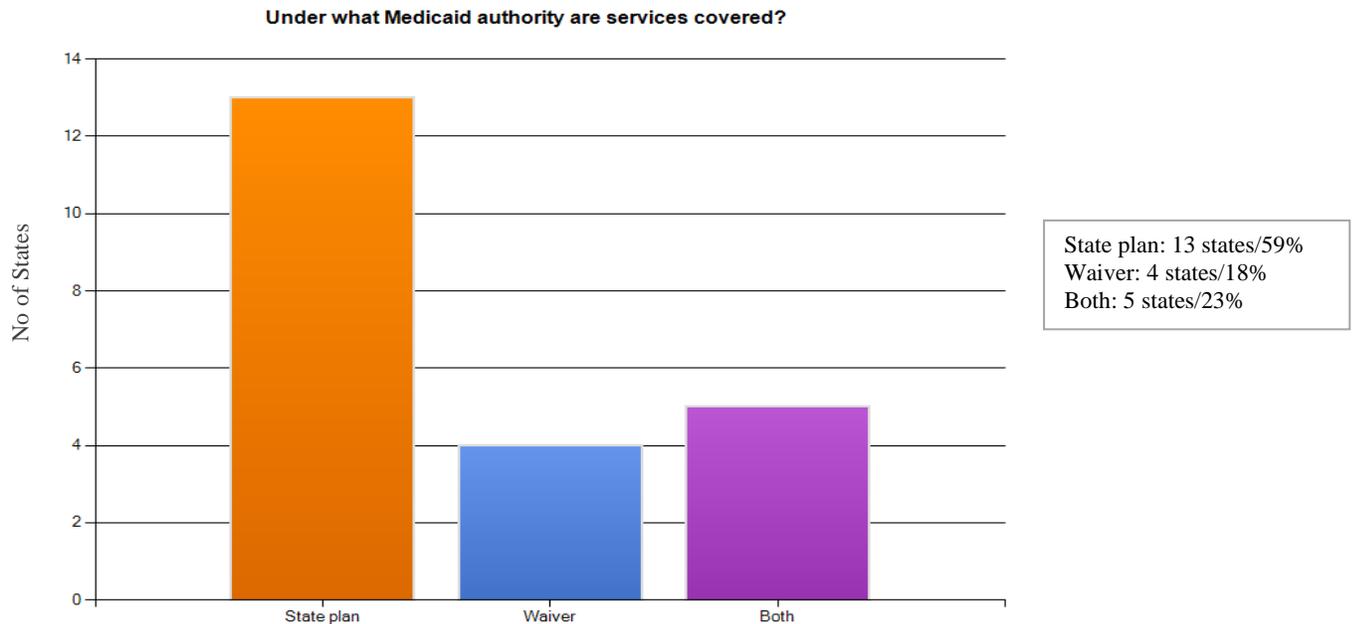
being covered under 1905(a), four states (80%) for 1915(b), one state (20%) for 1915(c), and one state (20%) for 1115.

The survey explored how services are reimbursed if the services are embedded in another payment rather than as a distinct service. The survey asked if reimbursement was through managed care organization(s) or through behavioral health carve out vendor(s). Out of twelve state responses, 50% reported reimbursement through managed care organization(s), 17% stated behavioral health carve out vendor(s) and 33% selected both options. Twelve states reported on the capitation rate: seven states (58%) reported that the cost of Peer Support Specialists was included in the capitation rate whereas one state (8%) stated that it was not, two states (17%) were unsure, and two states selected other. One responder for other indicated, “The costs of Peer Support Specialists (PSS) are funded by the savings from other higher end services in the capitation rate.”

**Figure 1**



**Figure 2**



### Services, Settings, and Payment Rates

The second area that the study focused on was types of services, settings and payment rates. Our findings on roles and functions of billable peer support specialists' included the following: individual peer counseling (92%), fill out forms (75%), crisis support (75%), group peer counseling (67%), and write progress reports (67%). In contrast, the roles of supervising other peers and family support had lower response rates. The programs that utilize Peer Support Specialists included: Assertive Community Treatment (68%), outpatient clinic (59%), community support programs (59%), day treatment (36%), jail diversion (36%), supportive employment (27%), supportive housing services (27%), respite (13%) and other (36%). Furthermore, the study showed that the most prevalent settings where peer support specialists are authorized to provide services included outpatient clinics (77%), consumer-operated peer centers (64%), psychosocial rehabilitation centers (64%), and residential (55%) whereas inpatient (27%) was identified as the least utilized (see <http://www.nasmhpd.org/PeerSupportServicesSurvey.cfm> for a full list of settings, and detail see slide 14).

The survey found that nine out of the twelve states reported rates based on fifteen minute increments. Of those nine states, the rates varied widely based on a Peer Specialist's level of education, the type of services being provided, the population being served, and whether services are provided by managed care organizations. For example, the lowest rate of \$3.30 (group – setting delivery model) per fifteen minute increment was reported for Peer Specialists without a Bachelor's degree in contrast to the highest rate of \$31.52 for skills training in the rehabilitation option. In response to the question about whether rates include fringe benefits, eight out of twelve states reported that they didn't know, three reported that all providers do include fringe benefits in the rate and one state indicated that some providers do. Finally, thirteen states (59%) reported that Peer Specialists were staff members and nine states (41%) reported that peer specialists were both staff members and contract employees. No states indicated that Peer Specialists were only contract employees.

## Qualifications and Training Curriculum

The last category of questions asked about the qualifications that Peer Specialists must have and their supervision and training. The findings included the following: seven states require a state certification or licensing process, nine states require passage of an exam or other certification, eleven states require completion of some form of a training curriculum, ten states required at least a high school diploma or GED, and seven states indicated the requirement to be a mental health consumer. Out of the twenty-two responses, five states specified the required number of training hours, which ranged with the lowest at 40 hours (Michigan, North Carolina, and Oklahoma) to the highest being 80 hours (Minnesota). Fifteen states (68%) require Peer Support Specialists to be supervised by mental health professionals, one state (5%) does not and 6 states (27%) reported other. In addition, fourteen states (64%) required continuing education in contrast to eight states (36%) for which continuing education was not required.

## **Part 3 – State Work Groups**

Through the course of the summit, participants were grouped into teams by state. States were represented by a wide variety of individuals, including State Mental Health Commissioners, Medicaid representatives, peer leaders, and other State administrators. There were three working sessions that addressed the three following topics:

- 1) In order to move forward towards establishing Medicaid billable peer support services our state would need to do the following activities;
- 2) We anticipate that the major barriers or challenges will be;
- 3) We may need technical assistance in the following areas.

Each state team completed a worksheet summarizing the findings of their discussions. For each of the questions several common themes emerged, which are summarized below:

- 1) In order to move forward towards establishing Medicaid billable peer support services our state would need to do the following activities:

The states reported a common set of issues for this question. Generally they described a process that involved identifying the key elements that would need to be put in place to support the initiative, including the identification and engagement of essential stakeholders. There would then be a period of convening stakeholders into a working team to map out and complete the work for accomplishing the goal. A common theme also centered on the entity that would develop the peer services. In most cases, this involved a state-wide infrastructure to administer the peer support services. In a few states, there was also discussion about the development of consumer run organizations that could lead this implementation process.

- 2) We anticipate that the major barriers or challenges will include:

A wide range of barriers were identified. Several states redefined the barriers into the notion of challenges that would impede the goals of developing Medicaid funded peer support services. The review of these barriers includes the following common themes. These are listed in a generally prioritized list by frequency of concern and response:

- Building and developing provider and system buy in for peer support services within a recovery based model.
- Funding limitations and Medicaid cost neutrality requirements.

- Newly elected state officials, their appointment of staff, and the transitions that occur in states after elections.
- Establishing employment standards and opportunities for the peer workforce, including job descriptions, roles, and supervision.
- The time and financial resources for startup initiatives.
- Medicaid.

3) We may need technical assistance in the following areas:

The state work teams also identified a set of common needs for technical assistance. Although listed in a range of responses, they are generally categorized into standard issues. These include the following in prioritized order:

- Help with the process of how to develop and implement a state Medicaid plan that will include peer support services.
- The availability of state plan language from states that have existing programs.
- Outcomes management, including existing data and ongoing measurement tools. These were identified in both the clinical area and the funding and return on investments.
- How to work with managed care organizations.
- Workforce development, including assistance with training and supervision, job descriptions, roles, and supervision.
- How to do billing for services and operations support.
- How to establish consumer-run organizations.

The combined efforts of the state work teams were identified by participants as a useful component of the Pillars Summit. The chance to work on issues within the state's organizations and the ability to compare findings with other states was rated highly in the feedback forms collected from the Summit. Generally the state level experiences, interest in peer support, challenges, and needs for technical assistance was common among participants.

The findings of these common challenges experienced by the states suggest various technical assistance (TA) needs. While most of the states' TA needs are similar, it is not clear how this TA can be developed to assist the states, and who will organize and fund such services. There was consensus among participants that with the proper assistance they would be interested and in a position to move forward with the goals of implementing Medicaid funded Peer Support Services.

### **Summary and Next Steps**

The Pillars of Peer Support Initiative has completed two phases. The initial phase constructed a series of twenty-five "Pillars" or fundamental principles that support and enhance peer support services. These were developed in a forum of participants from states that are currently billing Medicaid for peer support services. Based upon the overwhelming positive response from the field, a second phase was conducted to bring together those states that were not yet billing Medicaid for peer support services. In many of these states, there is already significant peer work being done throughout the state system. However, these states lack formal programs and are not yet able to bill services to Medicaid.

The goal for the second summit was to present key background material that would help the participating states better understand issues and challenges for implementing Medicaid reimbursable peer support services. The background materials included presentations from subject matter experts in peer support services implementation, the research base for peer support, and survey information on state level implementation of peer support services. States that participated in the Summit had a variety of representatives, including State Mental Health Commissioners, Medicaid representatives, peer leaders, and other State administrators.

The Pillars 2 Summit was a success in assembling background materials and convening key stakeholders. At the state level, processes were generated for how to approach the development and implementation of Medicaid reimbursement for peer support services. Barriers and challenges were also identified. Another valuable outcome was that the Summit helped States to identify areas where they might benefit from technical assistance in their efforts to develop and implement Medicaid-billable peer support services.

The key next step for the Pillars of Peer Support initiative is the recognition of the many aspects of technical assistance that were identified by Summit participants. It will be important to foster the development of these resources and to help secure the necessary financial support to make them available to the states. This could be accomplished by the development of a technical assistance center that is tasked to help foster the development of and reimbursement for peer support services at the state level. Another approach would be to establish an ongoing learning collaborative that brings together key stakeholders, to address ongoing challenges that states experience in developing Medicaid-billable peer support services. Any such efforts would likely need to be funded at the Federal level. States are financially strapped for resources, and although there is a clear intent, they are limited by scarce resources.

There is a unique opportunity for the development of peer support services in state behavioral health care systems. Medicaid is a viable funding source; however the development and implementation barriers are substantial. It will be incumbent on the leaders of the Pillars of Peer Support Services initiative, the funders and supporters of that initiative, participants of the two Summits, and other key stakeholders to continue to push the goal of having high quality peer support services available in all states. Peer support is a fundamental component of recovery and resiliency, and the development of such services should be a high priority for all funders, providers, and stakeholders in state behavioral health care systems

## References

- Chien, W., T., Thompson, D., R., Norman, I. (2008). Evaluation of a peer-led mutual support group for Chinese families of people with schizophrenia. *Am J Community Psychol.* Sep;42(1-2), 122-34.
- Clarke, G.N., Herinckx, H.A., Kinney, R.F., Paulson, R.I., Cutler, D.L., Lewis, K., & Oxman, E. (2000). Psychiatric hospitalizations, arrests, emergency room visits, and homelessness of clients with serious and persistent mental illness: Findings from a randomized trial of two ACT programs vs. usual care. *Mental Health Services Research*, 2(3), 155.
- Cook, J., Copeland, M.E., Hamilton, M., et al. (2009). Initial outcomes of mental illness self-management program based on Wellness Recovery Action Planning. *Psychiatric Services*, 60, 246 – 249
- Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 32(3), 443-450.
- Felton, C.J., Stastny, P., Shern, D.L., Blanch, A., Donahue, S.A., Knight, E., Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services*, 46(10), 1037-1044.
- Klein, A.R., Cnaan, R.A., & Whitecraft, J. (1998). Significance of peer social support with dually diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*, 8(5), 529-551.
- Lorig, K., Ritter, P.L., Villa, F.J., Armas, J., (2009) Community-based Peer-led Diabetes Self-management: a randomized trial. *Diabetes Educ.*, Jul-Aug: 35 (4) 641-651.
- Leropoli, S.C., White, V.M., Jefford, M., Akkerman, D., (2010) What models of peer support do people with colorectal cancer prefer? *Eur J Cancer Care*, Epub.
- Lucksted, A., McNulty, K., Brayboy, L., Forbes, C. (2009). Initial evaluation of the Peer-to-Peer Program. *Psychiatric Services*, 60, 250-253.
- O'Donnell, M., Parker, G., Proberts, M., Matthews, R., Fisher, D., Johnson, B., & Hadzi-Pavlovic, D. (1999). A study of client-focused case management and consumer advocacy: The community and consumer service project. *Australian and New Zealand Journal of Psychiatry*, 33, 684-693.
- Powers, S., Hagarty, J., (2010) Facilitated peer support in breast cancer: a pre- and post-program evaluation of women's expectations and experiences of a facilitated peer support program. *Cancer Nursing*, Mar-Apr;33(2) E9-16.
- Salzer, M.S., Schwenk, E., & Brusilovskiy, E. (2010). Certified peer specialist roles and activities: Results from a national survey. *Psychiatric Services*, 61, 520-523.

- Segal, S., P., Silverman, C., J., Temkin, T., L. (2010) Self-help and community mental health agency outcomes: a recovery-focused randomized controlled trial. *Psychiatric Services*. Sep;61(9), 905-910.
- Simpson, E.L., & House, A.O. (2002). Involving users in the delivery and evaluation of mental health services: Systematic review. *British Medical Journal*, 325, 1265.
- Solomon, P., & Draine, J. (1995). The efficacy of a consumer case management team: 2-year outcomes of a randomized trial. *The Journal of Mental Health Administration*, 22(2), 135-146.
- Travis, J., Roeder, K., Walters, H., et al. (2010). Telephone-based mutual peer support for depression: a pilot study. *Chronic Illness*, Sep;6(3), 183-91.
- Woodhouse, A. and Vincent, A. (2006) Mental health delivery plan—development of peer specialist roles: A literature scoping exercise. Scottish Recovery Network and the Scottish Development Centre for Mental Health, Edinburgh.
- Yanos, p., T., Primavera, L., H., Knight, E., L. (2001) Consumer-run service participation, recovery of social functioning, and the mediating role of psychological actors *Psychiatric Services* 52:493-500.