PEER SUPPORT SPECIALISTS AS DRIVERS OF INTEGRATED HEALTHCARE

The Challenge

The health care system is extremely complex, fragmented and made even more challenging when one is managing a behavioral health condition in addition to other acute and chronic medical conditions. Both consumers and providers are aware of the need for integration and coordination across conditions and specialties but struggle with billing, scope of practice, privacy and time issues. Consumers, who are increasingly skilled at advocating for their own and the needs of others who are managing mental disorders similar to their own, are particularly aware of the inadequacies and challenges of the healthcare system as it stands now. Peer support specialists, the title for consumers who work in the field of mental health services provision, whether additionally trained, employed or serving in a voluntary role have an important and unique role to play in assuring that the integrated healthcare model is designed to be patient centered; that it is respectful of customer needs and desires; that it makes provisions for education and support and that shared medical information is respectful of privacy but also enhances the quality of care that they receive. Also, peers who straddle both worlds have been shown to be effective members of the case management teams (a key component of integrated healthcare), skilled providers in self management and social support as has been throughout the recovery movement, and advocates for individual care and system change.

In conditions as complicated as mental health disorders wherein primary healthcare providers are often providing care for mental as well as physical symptoms but may be unaware best practice in mental health, underestimate the need for follow up and monitoring and may refer inadequately, the need for coordination and integration is paramount. Not only are physical and mental health interrelated so that a change in one impacts the other, but the treatment regiment of mental health disorders also has many physical side effects and impacts on a person's propensity for a variety of primary and secondary health conditions. A consumer's mental health conditions (and to large degree the associated treatments for these conditions) may cause, exacerbate or present additional physical symptoms. Mental illness is also extremely common, 26.4 percent of Americans suffer from a diagnosable mental illness every year. (Collins, 2010). This means that primary care doctors who are only marginally trained to recognize, diagnosis and treat mental illness have a 1 in 4 chance that their patient who is presenting with a physical symptom is also managing (perhaps very poorly) a mental health condition.

Even when physicians are able to understand the impact of mental illness on their patient, their medical practice is rarely set up to provide extra time, support, management and education that patient may need. Without compensating for these factors, it is unlikely that the United States will be able add back the nearly 25 years of life that an individual loses just because he or she is living with a mental illness. (National Association of State Mental Health Program Directors, 2006). Factors for these poor outcomes are interrelated. They include "factors relating to having a mental illness, the fragmentation of health care, health behaviors such as smoking and physical inactivity and the effects of psychotropic medication as well as the fact that individuals with mental illness are not screened as regularly on physical health indicators." (Robson, 2007). Since stigma around mental illness often causes individuals with mental illness to rely only their primary care provider, integration into primary care remains the efficacious manner in identifying and treating mental illness in individuals and populations. Perhaps the greatest role that peer providers can provide is simply to remove the barriers to care by fighting the stigma associated with seeking care and advocate for

enhanced care in the primary health care setting.

Considering the high prevalence of mental health conditions and the propensity of the population to seek present to their physicians with physical conditions that impact on or are impacted by managing a mental health condition, the benefits of integrated healthcare and its closely linked concepts of patient care and medical homes, movement to towards reaching fulfilling the tenets of these concepts is a sound way of improving comprehensive health care, improving physical and behavioral outcomes and managing skyrocketing costs. There is no question that there is a role for peer providers.

Individuals who are managing their mental health condition are becoming more vocal in their desire to participate equally in the management of their condition, advocating for the ongoing nature of recovery from their mental health condition and offering their support and expertise to others who are seeking to better manage their mental health condition. This advocacy has resulted in the creation of multiple self help opportunities for individuals seeking to improve their outcomes and career opportunities for those who are employed as paraprofessionals in this field.

Also, consider the patient centered care aspect of integrated health care. It is easy to identify roles which peers would be uniquely suited to serve. According to Shaller (2007) , the six key markers of patient centered care are

- Education and shared knowledge
- Involvement of family and friends
- Collaboration and team management
- Sensitivity to non medical and spiritual dimension of care
- Respect for patient needs and preferences
- Free flow and accessibility of information

In five of these six principles, peers as paid professionals in case management or service provider positions or as peer providers in other roles could and should have a significant contribution to make. Recommendations to utilize peer support specialists as primary advocates, care providers and community supports are easily linked to providing high quality patient centered care. The literature around the use of peers is explored in the next section.

What the Literature Says

“Peer Support Specialist” is a common name given to the hybrid blend of mental health provider and social support friend. Their roles are varied. This lack of formal definition in their scope of practice is problematic in their integration into the mental health field and will also be challenging in some of their proposed roles in integrated healthcare provision. There has, however, been considerable movement in defining and solidifying their roles already. Peer support specialists are achieving greater levels of definition and professional training and are playing a greater roles in the provision of services and as advocates.

The trends of peer providers and the push for integrated health care have co-existed for years and their paths have intersected and no doubt will continue intersect even more frequently. Rather than wait for them to collide randomly, it is worth exploring how they might enhance each other. Peers are asked to straddle the professional and patient divide in their work. They are in a unique position to serve as advocates for health care integration and also serve in paraprofessional roles successfully. (Studies generally show that peers can attain professional rates with adequate training

and support. (Simpson, 2002.) They have been especially vital in case management initiatives and case management and self management functions, both of which are key functions in integrated health care.) Peer support specialists' first hand knowledge of managing a mental illness gives them a unique perspective on system function (or dysfunction) and they can advocate with authority for the need for enhanced care integration. They are in position to advocate for change from both groups and design systems that are palatable for both the consumers and the providers.

In order for peers to be utilized in their most effective manner, they must receive adequate support, direction and training. Although studies consistently show that they can show results similar to other professionals in the area of case management and self management, it does require providing support. (Fellow, 1995, Solomon, 2004; Simpson 2002, Davidson, 2006) Peer providers do bring unique strengths and abilities to any support they provide but they also usually bring a service orientation that is recovery oriented. They consider some of their strengths in providing services to be use of experiential learning processes, use of mutual benefit, use of natural social support, voluntary nature of the service, primary control of the service by individuals with psychiatric disorders, and reflective of the cultural diversity of the community. (Solomon, 2004). Obviously, these tenets while not at odds with definitions of integrated healthcare such as the one from the Institute of Medicine which focuses on communication between all clinicians who are caring for a consumer; collaborative work around the establishment of decision making and the scope of practice for each of the providers; care coordination; shared documentation; and the ability to bill for the supports and staff necessary to make these things a reality (Institute of Medicine, 2005, November.) However, agendas must be managed proactively. Accomplishing this objective will require melding two cultures: the consumer recovery movement with its informality vision and energy and the bureaucracy of service payers such as Medicaid or even private insurance with their complex bureaucratic requirements. (Salzer, 2010, May).

There are additional challenges to the marriage of integrated care and peer providers. Even in traditional mental health settings, peers are not always utilized to their full extent. This body of research speaks to the strength of the intervention and the wide support for it among providers and customers since the intervention has only been widely used since the early 1990s (Davidson, 2006). This has not been a easy transition. According to Davidson:

> *"Peer staff have been viewed with varying degrees of suspicion concerning their having potentially been co-opted by the mental health system. The development of peer based interventions outside of mutual support and peer run settings on the other hand, has served to bring peer support closer to the mainstream of mental health practice. The presence of a review of the empirical evidence for this practice in the journal is one indication of this change." (Davidson, 2006).*

Before further discussion of peer integration, it is important to note primary care doctors are not universal in their support of integrated care and/or a medical home either. Most do not perceive their care as lacking nor do they perceive benefits or the appropriateness of their role in many of the care/case management functions associated with medical model. Additionally, for small practices systemic changes are proportionally more significant, more expensive per patient, and more practice altering. This is especially true of small practices of with five or fewer providers. (Berenson, 2008). If a primary care home model is adopted, consumers will need to advocate for the inclusion of anything other than basic primary health provision especially those related to behavioral health since at least some (27-44%) do not see the need for additional care coordination even if additional funds are provided for these functions. (Berenson, 2008). Adding peer providers to this equation could add another perceived barrier to health care integration. However, peer providers can also passionately advocate for the need for integrated health and be active players in case management and self management efforts.

Even if the above issues are resolved, patient and billing issues need to be settled. Within these solutions lies increased roles and function for mental health services and/or peer providers. Patients are reluctant to submit to a traditional mental health regiment. Primary care patients will tolerate only about three hours of "treatment" over a three-month period for conditions like depression. For example, a cognitive behavioral approach to panic disorder can be done in three to four brief contacts, when supported with educational materials, home practice, and telephone follow-up (Robinson, 2005). This nugget of information on patient behavior leads opens itself up to the development and delivery of services in bit size pieces. This is a role in which adequately trained and supported peer providers could participate. Key features of the primary care behavioral health model include "warm handoffs" in which the physician introduces the behavioral health clinician directly to the patient and "curbside" consultations in which the physician and behavioral health clinician have frequent informal interactions to discuss patients (Collins, 2010, May). Peers have had a role in all of these functions previously and the research has shown that they participate in case management, education and other support functions. The initiative is as effective and occasionally more effective than those done in a traditional client-provider nature.

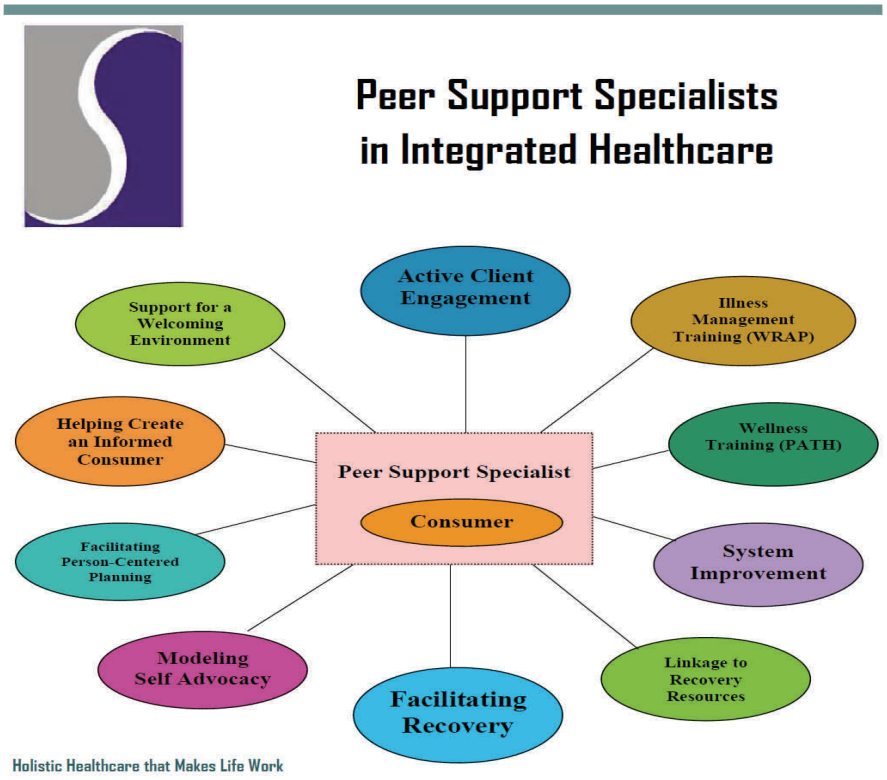
The barriers can be opportunities for peer support providers. There are many recommendations that can also direct their specific roles and function. These providers have the experience of navigating treatment for both their physical and mental healthcare and can speak with authority on what systems would support the best outcomes, the most ease in service delivery and feel most comfortable for consumers It must also be stated that these providers are while specially trained are often less expensive choices and/or billed through therefore, could provide greater amounts of support and expertise without negatively impacting on productivity. Consumers (in this case functioning as peer providers) are specifically mentioned by the National Association of State Mental Health Program Directors (NASMHPD) in some of their works. NASMHPD suggests that peers provide support and advocacy in the following ways:

- Share information widely about physical health risks in persons with SMI to encourage awareness and advocacy.
- Educate the health care community.
- Encourage persons served and family members to advocate for wellness approaches as part of recovery.
- Build on the development of SAMHSA evidence-based practices by creating a toolkit that is focused on health status and healthy lifestyles.
- Promote adoption of recommendations in the NASMHPD Technical Reports on Polypharmacy and Smoking to implement policies and programs addressing these risk factors. (Morbidity and Mortality in People with Serious Mental Illness, 2006.)

The Findings from the Integrated Healthcare Block Grant

The Integrated Health Initiative planned to make Peer Support Specialists central to the success of the Project. The Project secured a contract with the SHARE Center (the peer-owned and operated Drop-In Center in Calhoun County) to provide Peer Support Specialists (CPSS) who were certified by the State of Michigan as Medicaid providers and trained in the PATH competencies. PATH (Personal Action Towards Health) is the Michigan stemming from the work of Kate Lorig and the Stanford Chronic Care Program for providing training in wellness/illness self-management to persons with serious mental illness. [The SHARE Center provided 2 Master Trainers and 4 Lay Leaders trained in PATH.]

The primary tasks of the CPSSs were to engage consumers in linking with the embedded Primary Care Practice within Summit Pointe; to foster increases in wellness behaviors through the provision of self-help group services; and to advocate for and mentor consumers in their interactions with healthcare systems. The diagram below describes the desired CPSS behaviors.



The key to success was the formation of close mentoring relations with consumers. This was encouraged by the CPSS ability to cultivate referral and support relationships with clinical staff within Assertive Community Treatment (ACT), Case Management, Outpatient, and Housing Programs.

Participating Consumers were quite satisfied with the services of CPSSs as medical mentors as evidenced by their positive responses on satisfaction surveys; their continued attendance at scheduled primary care appointments; and their positive wellness-related behaviors following participation in wellness programs.

Simply, the Project would not have been as successful without the active planning and participation of the CPSSs.

Recommendations

- Clearly define the role of peers in driving any initiative by delineating the scope of practice and clear role expectations. Help providers and peers manage the natural tensions that

occur as peers navigate their roles as consumer and provider. This recommendation should be a part of any peer initiative.

- Utilize peers in advocacy functions, to increase understanding of patient perspective particularly when helping classically trained providers in understanding shared decision making.
- Encourage the use of peer providers in the development of culturally competent and appropriate screening tools, "bite size" educational and therapeutic interventions to be utilized in primary care settings.
- Participate in the development of and implement toolkits and guidelines to help providers, self-help/peer support groups and families understand how to facilitate healthy choices while promoting personal responsibility. These will be needed as primary care providers recognize the need for resources in the community for individuals needing greater interventions.
- Utilize peers on case management teams which are developed as part of care integration efforts. Provide adequate training and supervision of their efforts so they can be effective and productive in their efforts.
- Design and evaluate the inclusion of peers throughout the healthcare integration process since this role for peers is groundbreaking.
- Increase the roles for peers in self management instruction including topics relating to balancing healthy lifestyle choices with managing a mental health condition.

Select Reading

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