

Peer Support Best and Promising Practices

Office of Mental Health and Substance Abuse Services

March 20, 2015

Agenda

1. Background and Introduction
2. Findings
3. Recommendations
4. Questions and Discussion



Background and Introduction

- **What are Peer Support Services (PSS)?**
 - Recovery is possible!
 - Areas of recovery:
 - Managing illness (health)
 - A place to live (home)
 - A reason to live (purpose)
 - Relationships with others (community)
 - Recovery is supported by peer specialists who have had similar experiences.
 - PSS may be provided as a stand alone service or embedded within a clinical service.

- **The Goals and Expected Outcomes of PSS are to:**
 - Foster an attitude of hope, self-efficacy, and well-being.
 - Help individuals learn to manage their own recovery and advocacy process and to acquire skills and knowledge needed to facilitate their own recovery.
 - Identify services and supports to promote and foster recovery.
 - Help individuals develop community relationships and natural supports.
 - Create an improved quality of life.
 - Reduce costs associated with higher levels of care as individuals learn to more effectively manage their illness.

- **History of PSS in Pennsylvania**

- In 2004, the Office of Mental Health and Substance Abuse Services (OMHSAS) received a three year Mental Health Systems Transformation Grant from the Centers for Medicare and Medicaid Services (CMS) to implement Medicaid-funded PSS.
- In 2007, CMS approved Pennsylvania's Medicaid State Plan Amendment in which PSS was included as a component of rehabilitative services.
- Since then, OMHSAS has cultivated additional PSS specialty areas and, as of June 2014, certified more than 3,200 peer support specialists.

- **Current PSS Practice in the Commonwealth**
 - PSS practice standards are outlined in Bulletin OMHSAS-09-07, Peer Support Services-Revised.
 - The priority population are adults diagnosed with a serious mental illness as outlined in Bulletin OMH-94-04.
 - Reimbursement is limited to a maximum of 16 units/day/individual and no more than 25% of PSS provided to an individual in a calendar year can be telephonic.
 - The Bulletin references medical necessity criteria for initiation, continuation, and discharge from PSS.
 - The Certified Peer Support Specialist certification process is administered by two private agencies under OMHSAS oversight.



Findings

- **Research Questions about PSS Best Practices**
 - Referral to mental health PSS:
 - Who is most likely to benefit from PSS?
 - Are there situations in which referrals to PSS may not be indicated or medically necessary?
 - What medical necessity criteria have been used to authorize entry into and continued stay in PSS?
 - Service delivery and outcomes tracking:
 - How should the needed frequency, intensity, and duration of PSS be determined?
 - What are best practices for setting realistic goals and tracking member progress in PSS?
 - Transition out of PSS:
 - What are best practices to safely and effectively transition members out of PSS once their goals have been achieved?

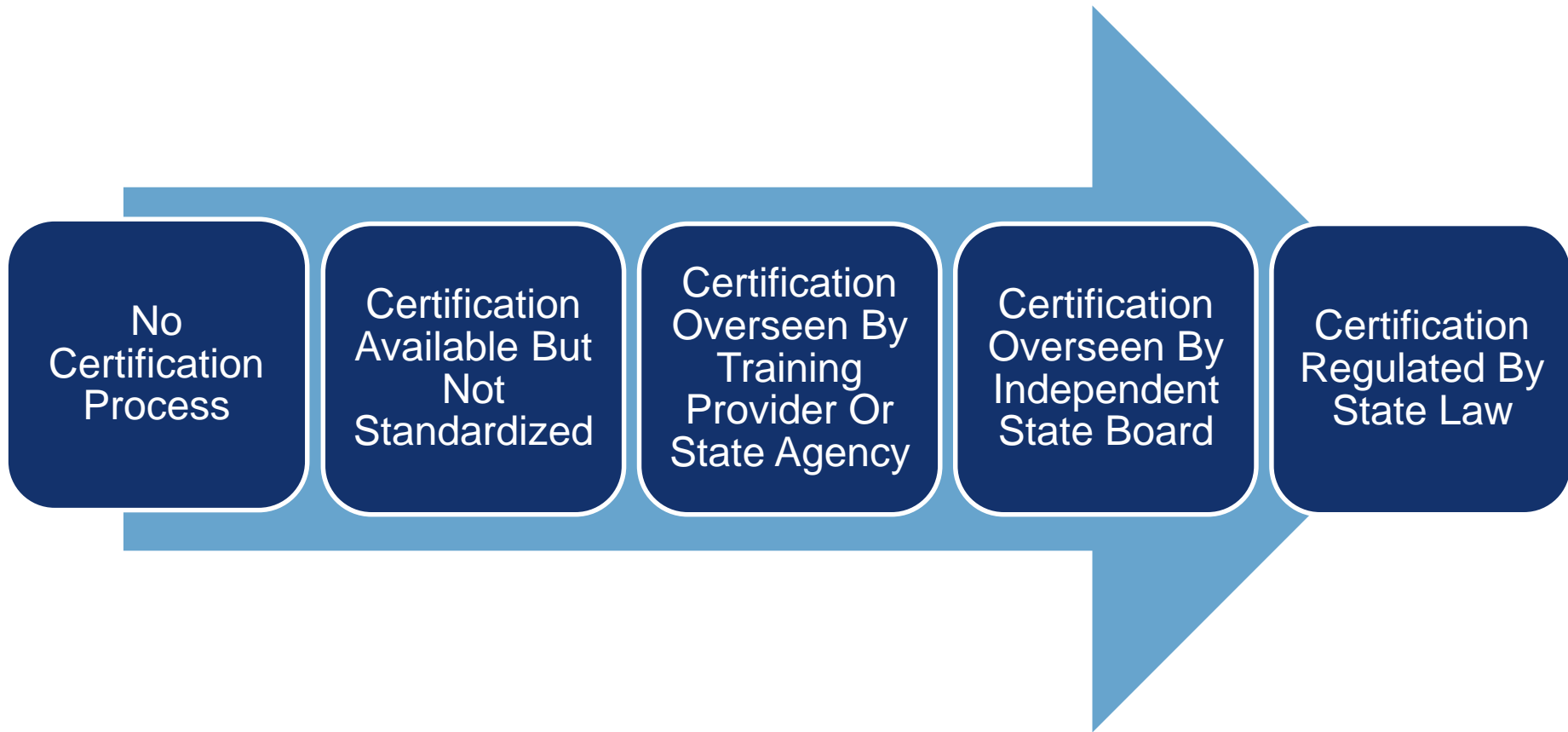
- **Findings: Referral to Mental Health PSS**
 - **Behavioral Health-Managed Care Organizations (BH-MCOs):** Identified the priority population as primary PSS recipients and use a variety of utilization management approaches.
 - **States:** PSS recipients similar to the Commonwealth's priority population. Variations include additional criteria, a pilot program for family-to-family PSS, and using alternative funding sources to expand to individuals with substance use disorders.
 - **Model PSS Programs:** Those most likely to realize full benefits of PSS are voluntary participants, have hope, and are able to function in a group milieu (if applicable).
 - **Literature Review:** Most states use similar priority population parameters as the Commonwealth. Five states include other age groups.

- **Findings: Service Delivery and Outcomes Tracking**
 - **BH-MCOs:** Data collection varies across BH-MCOs. Those who collect data note variation in utilization, duration, and intensity. Two BH-MCOs are engaging in a deeper analysis of outliers. Many of the BH-MCOs report increased utility by embedding PSS within other clinical services.
 - **States:** Describe continued stay criteria as “loose” with few denials. None of the interviewed states are tracking duration or intensity.
 - **Model PSS Programs:** Those PSS programs that track length of stay report considerable variability. Programs reported a variety of models and practices.
 - **Literature Review:** A general theme is the limited empirical-based knowledge about best practices for PSS delivery and outcomes tracking. However, certification processes for providers of PSS are now present in most states, but there is great variation in terms of who administers the process and how formalized it is.

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- **Findings: Transition Out of PSS**

- **BH-MCOs:** Although all BH-MCOs referenced discharge criteria from the Bulletin, many also stated that the topic is underdeveloped. Two BH-MCOs mentioned the availability of club houses and drop-in centers as important to transitioning out of PSS.
- **States:** In general, the states interviewed reported that discharge criteria from PSS is not an area of current focus. Several states noted that PSS recovery goals target developing community supports.
- **Model PSS Programs:** Transitioning to community supports should be embedded in recovery goals. Innovative approaches to overcoming barriers to transition out of PSS were noted.
- **Literature Review:** Other than discharge criteria, no research was found that addresses safe and effective transition from PSS into community supports.



Recommendations

- **Recommendations: Referral to PSS**
 - Identify specific clinical indicators for potential high-impact PSS referrals.
 - Gather the collective clinical expertise of providers, BH-MCOs, and stakeholders to develop a set of clinical indicators of individuals for whom PSS may have the most significant impact in terms of quality of life and clinical dollars saved. Clinical indicators might include non-engagement with traditional health systems or multiple admissions to higher levels of care.
 - Ensure that providers, care managers, and care coordinators are trained to refer individuals with these indicators to PSS.
 - OMHSAS could require that these indicators be included in BH-MCO training of clinical staff and network providers.
 - In data-gathering initiatives described later, OMHSAS can validate these indicators with associated cost trends.

- **Recommendations: Referral to PSS (cont'd)**
 - Evaluate potential cost-savings from expanding the populations that may receive PSS.
 - In collaboration with stakeholders, explore funding, programming and utilization/outcome measures to evaluate the efficacy of expanding PSS to other populations such as transition age youth, family-to-family programs, and/or individuals recovering from substance use disorders.
 - OMHSAS may use the data gathered from these pilot programs to make data-driven decisions about the role of PSS in HealthChoices in the future. If indicated, these results can be used to make a compelling business case for PSS expansion.

- **Recommendations: Service Delivery and Outcomes Tracking**
 - Identify and collect standardized utilization, outcome, and cost trend data about PSS.
 - In collaboration with stakeholders, develop metrics and specifications for tracking utilization, duration, and intensity of PSS. Generate a statewide report that is monitored by the stakeholder group to monitor for trends and patterns.
 - To fully understand the impact of PSS within the behavioral health delivery system, identify PSS cost trends in concurrent, higher levels of care to increase the focus on the quality and effectiveness of PSS. Track and monitor these cost trends. Eventually may be used for performance goals.

- **Recommendations: Service Delivery and Outcomes Tracking (cont'd)**
 - Establish guidelines for recovery plans and goals.
 - In collaboration with stakeholders, develop guidelines that target increasing autonomy and independence. Guidelines may include a “discharge vision”. Resulting guidelines could be incorporated into OMHSAS’ service definition or used as a part of primary contractor/BH-MCO utilization management activities.
 - Strengthen the current certification process for PSS to support continued expansion to other populations and to reinforce its vital role within the larger behavioral health workforce.
 - In collaboration with stakeholders, identify the most appropriate state certification board, develop formal written standards, rules and regulations consistent with statutory authority.

- **Recommendations: Transition Out of PSS**
 - Develop statewide surveys for PSS recipients to identify best practices and training opportunities.
 - In collaboration with stakeholders, develop an “exit survey” for individuals who successfully or unsuccessfully transition out of PSS. The survey would identify those components the individual found helpful and those they did not find as helpful in fostering autonomy.
 - Develop a second survey for individuals with longer PSS tenure to assess barriers or reasons why an individual may be hesitant to transition out of PSS. Reasons may vary from systemic issues (i.e., lack of community-based resources) to individual issues (i.e., complexity/challenges to meeting recovery goals, growing dependency on the PSS relationship).
 - Initial survey development may require pilot studies with narrative responses. Ideally the final surveys would be online with reportable fields that automatically generate reports.

- **Recommendations: Transition Out of PSS (cont'd)**
 - Identify and embed best and promising practices in an ongoing quality improvement process.
 - As some or all of the data collection approaches identified in these recommendations are implemented, OMHSAS, BH-MCOs, providers, and other stakeholders can use this information to create an iterative quality improvement process that continues to increase the quality and effectiveness of PSS in the Commonwealth.



Questions and Discussion