

**Testimony**  
**Health Services Interim Committee**  
**Senator Lee, Chairman**  
**September 21, 2016**

Chairman Lee and members of the Committee: my name is Carlotta McCleary. I am the Executive Director of Mental Health America of North Dakota (MHAND). MHAND's mission is to promote mental health through education, advocacy, understanding, and access to quality care for all individuals.

MHAND recently received a Targeted Technical Assistance Grant from Substance Abuse and Mental Health Services Administration (SAMHSA). The goals of this grant were to develop peer support specialist training curriculum and develop standards of practice for peer support specialist. Dr. Karen Kangus from Recovery University in Connecticut came to North Dakota to provide technical assistance to MHAND. Dr. Kangus spent a week providing training and technical assistance to our staff. We also met with consumers and the Behavioral Health Division. We had the opportunity to see the curriculum that Recovery University is utilizing in the state of Connecticut. This is currently the state certified certification process for the state of Connecticut. The curriculum was written by Chyrell Bellamy, PhD, MSW Yale School of Medicine. Dr. Bellamy has conducted research regarding the Evidenced-based Practices of Peer Support. This curriculum is considered one of the best in our country. Recovery University students must attend the 80-hour course and need pass the final exam in order to receive certification.

Last week I had the opportunity to visit Connecticut and see how they were utilizing peer support. I met with Dr. Miriam Delphin-Ritteimon, State of Connecticut, Mental Health and Addiction Services Commissioner, Dr. Chyrell Bellamy, Yale University School of Medicine as

well as clinicians and recovery support specialists working in state and private nonprofits to really see how Connecticut was utilizing peer support across the state. One clinician working for the state called the use of peer support to be truly transformative in the way all services are provided.

We are currently working with Advocacy Unlimited, which houses Recovery University on an agreement for MHAND to use the curriculum. We are looking forward to having such a wonderful training and certification program in North Dakota.

I am including the PowerPoint titled Evidence-based Practices of Peer Support for additional information regarding Peer support.

Thank you for your time.

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# Creating Replicable and Sustainable Peer Support Services

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## Background

Centers for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), and most national behavioral health experts promote peer support and, indeed, the last decade has experienced a substantial increase in peer support services.<sup>1</sup> Unfortunately, the empirical evidence supporting peer-provided services lags behind their rapid proliferation. Studies that do exist rarely evaluate the unique aspects of the service.<sup>2</sup>

In an effort to proffer peer support for system-wide implementation, OptumHealth<sup>SM</sup> tasked a group with understanding and documenting the components necessary for implementation, replication and sustainability of peer support services. A pilot, with two sites, was designed and implemented as a way to determine those systems and processes.

An independent evaluator was chosen to document the empirical evidence gathered through the pilot and an internal OptumHealth team monitored the design and operational activities from pre-pilot to post-pilot.

## Methods

Peer Bridger was chosen as the specific peer support model to be implemented and measured in the pilot.

*Peer Bridger services, originally developed in 1994 by the New York Association of Psychiatric Rehabilitation (NYAPRS), are provided by individuals in mental health and/or addiction recovery who are trained in peer support and often certified as peer specialists or peer wellness coaches. They offer engaging hope and recovery focused mutually accountable relationships that help individuals meet their personal health, wellness and life goals. Peer bridgers provide transition assistance and linkages to services and natural supports in the community by offering individualized support for effective wellness management, independent living, social skills, and coping skills. Peer Bridger services are most often provided for individuals leaving inpatient treatment or other segregated environments such as residential treatment, adult (board and care) homes, prisons and jails.*

<http://www.nyaprs.org/peer-services/peer-bridger/>

Services – called PeerLink due to potential confusion with an existing Tennessee consumer program named Bridges – were developed for pilot sites in southeast Wisconsin and West Tennessee, along with Grassroots Empowerment Project (GEP) and the Tennessee Mental Health Consumer Association (TMHCA) as provider partners. OptumHealth, GEP and TMHCA worked collaboratively to design the pilot and to implement services. The pilot began in December 2009 and ended August 31, 2010.

<sup>1</sup> The Pillars of Peer Support Services Summit. *Pillars of Peer Support: Transforming Mental Health Systems of Care through Peer Support Services*. (Atlanta, Georgia. The Carter Center Nov 17–18, 2009) 1.

<sup>2</sup> Davidson, L., Chinman, M., Sells, D., Rowe, M. (2006). Peer Support Among Adults with Serious Mental Illness: A Report from the Field. *Schizophrenia Bulletin*, Feb 3, 2006.

The most impactful method of ensuring that peer support is implemented and sustained system-wide is to show its cost effectiveness. The objective of this project was to demonstrate that Peer Bridger services decrease psychiatric inpatient bed days.

Dr. Chyrell Bellamy and her associates at Yale University's Program for Recovery and Community Health conducted the independent evaluation that included an analysis of the following: 1) hospital authorization data, 2) Peer Support Specialist encounter data, 3) surveys from OptumHealth staff, 4) Peer Specialist focus groups and 5) surveys from and focus groups with pilot participants.

Additionally, an internal team conducted a process evaluation, and lessons learned were observed and documented throughout the project. The programs were not static; each site matured and changed as new information became available. Services continued at both sites following the pilot.

## Results

### Empirical Evidence

Hospitalization data were analyzed for PeerLink members who had a history of at least one hospitalization from December 2008 through the month preceding enrollment in PeerLink. This subsample included 28 PeerLink members in Tennessee and 65 PeerLink members in Wisconsin.

Hospitalization Data		
	Tennessee Peer Link (n = 28)	Wisconsin Peer Link (n = 65)
Average number of hospital days per month		
Before PeerLink	7.42 (7.52)	.86 (.83)
After PeerLink	1.98 (3.65)	.48 (.93)
Decrease in average number of hospital bed days	73.32%	44.19%

Note: Before PeerLink = the average number of hospitalizations in the months prior to an individual's first date of PeerLink Service. After PeerLink = the average number of hospitalizations in the months including and after the first date of PeerLink service.

## Results

### Process Evaluation

Sample list of issues that can result in termination of a peer support program	
Issue	Solution (not an exhaustive list)
Inability to measure outcomes or determine cost effectiveness	1) Distinctly defined levels of peer support services, 2) Process that allows encounter data to be stored and compared with other service data
Lack of billing and/or claims processing expertise (a provider and payer problem) results in poor payment history	1) Detailed contract with no room for misunderstanding, 2) Prior to service implementation, payer can verify that all claims processes support payment of non-licensed providers, 3) Payer ensures a single point of contact for providers with billing and claims knowledge, 4) Provider training
The program faces constant setbacks and nothing ever gets resolved	Partnership participants matter. The payer organization must be willing to truly integrate peer support in the service array, modify systems when needed, and provide a champion to keep the process moving. The provider organization must have strong leadership with a desire and the skill set to provide the services being purchased and to offer ongoing training and supervision for its employees.

## Reason(s) Research Can Be Considered a Disruptive Innovation

The independent evaluation of the PeerLink pilot adds to the body of knowledge verifying that peer support is effective and increases community tenure for its recipients.

The process evaluation provides a checklist for future implementations of peer support services and begins to offer guidelines for program sustainability. As a result of the project, OptumHealth is developing Level of Care Guidelines for seven distinct levels of peer or family support services, is developing credentialing criteria for both peer and family provider organizations, and is clarifying the claims process from point of service to provider payment to ensure that providers are not financially at risk.

**OptumHealth<sup>SM</sup>**  
Public Sector

## Implications for Behavioral Health Practice, Policy, and/or Research

Widespread peer support services will change the face of behavioral health – practice, policy and research. Full integration of peer support services facilitates recovery and a cadre of recovering consumers will truly create disruptive innovation.