State Roadmap to
Peer Support Whole Health & Resiliency

The SAMHSA has released innovative Recovery Support Definitions which further the unique roles of Peer Specialists with the vision of their role in the integration of behavioral health and primary healthcare. Specifically, its **Relapse Prevention/Wellness Recovery Support** definition builds upon the foundation of a professional peer workforce with lived experience and furthers their scope to create thoughtful new opportunities for Peer Support in healthcare. Peer Support Whole Health and Resiliency (PSWHR) promotes developing whole health and wellness behaviors through the development of whole health and resiliency goals (SAMHSA-HRSA CIHS, 2011).

One of the greatest challenges in healthcare is engaging the individual in his/her own healthcare management. Mauer and Druss (2011) define the need for developing an "Informed, Activated Patient" including:

- **Self-management** : ability to understand and manage one's health and medical problems
- **Activation**: ability to act effectively in managing one's own healthcare

For individuals who are striving to achieve and maintain recovery with a mental illness or addiction, there may have been historical barriers to engaging in traditional healthcare systems. Therefore self-management and activation are not outcomes which have been achieved (NASMHPD, 2006). A natural ally for engagement in health is a professional who has walked in the same shoes: a health-trained peer practitioner. The peer perspective may be the key, as it models this "self-management," while encouraging health activation.

Additionally, because of their lived experience including challenges accessing health as a person with a behavioral health issue, peer practitioners have a niche role in supporting and motivating the individual toward health, wellness, and resiliency. Their strengths-based approaches are essential to health teams including but not limited to those in a health home model (which currently has 90/10 match opportunities for initial 2 years of implementation), Federally Qualified Health Centers (FQHCs), and emergency rooms. Trained Peer Specialists can also be a tremendous aides in health workforce shortage areas and be key partner in rural health centers.

Peer Support Whole Health and Resiliency can be utilized in many settings. Once you have some ideas on your broad approach, the following definition and roadmap will provide checkpoints to you and your health partners as you consider the role of peer professionals in the changing landscape of health and wellness.

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SAMHSA-HRSA Center for Integrated Health:
Relapse Prevention/Wellness Recovery Support Definition

Relapse Prevention and Wellness Recovery Support Services are designed to address the further needs of people who are working to develop or who have developed a Recovery Plan. Relapse Prevention and Wellness Recovery Support Services include activities to develop and implement strategies or treatments applied in advance to:

- Prevent future symptoms of and promote recovery strategies for addressing mental illness and/or substance use disorders
- Reduce the adverse health impacts related to mental illness, substance abuse, and related traumatic experiences
- Build on, and /or maintain wellness skills learned in medical, behavioral health, and related trauma treatment and allied recovery support services
- Link to other services that promote recovery and wellness, which are considered relapse prevention and wellness recovery support activities
- Relapse Prevention and Wellness Recovery Support can be built into the responsibilities of a Peer Recovery Coach or a separate service role that can be filled by a Peer Recovery Coach, among others.
- Relapse and Prevention and wellness recovery support services:
- Provide or reinforce the individual's education, and understanding of factors that threaten recovery from mental and substance use disorders, including violence, abuse, neglect, and other environmental, interpersonal dynamics.
- Include recovery planning, recovery management, and adaptive skill training to promote wellness.
- Deliver skills for reinforcing abstinence from substances where necessary, engagement in health behaviors, and recovery maintenance.
- Utilize community resources, including natural and peer supports to maintain recovery and wellness patterns of thinking, and behaviors to mitigate relapse-provoking crises.

EXPECTED OUTCOMES:
Expected outcomes should be consistent with those indicated in the individual's recovery/and wellness plan. These may include the following:

- ✓ Continued length of abstinence from substances
- ✓ Improved bio-psychosocial health
- ✓ Increased ability to identify and manage high-risk situations that could lead to relapse
- ✓ Increased ability to be proactive regarding relapse prevention and wellness recovery planning including the ability to identify warning signs and triggers and to adhere to self-defined goals and strategies to maintain abstinence and wellness achievements
- ✓ A reduction in mental illness and/or substance use disorder services as individuals assume responsibility for their own wellness and recovery stability, manage and reduce their symptoms through varied self-help techniques and initiate the support of a network of peer, indigenous community and professional supports
- ✓ Increase in stable housing and employment
- ✓ Increased linkages made to other recovery and wellness support services
- ✓ Increased overall quality of life

Additional detail @ http://www.samhsa.gov/grants/blockgrant/Relapse_Prevention_Wellness_Recovery_Support_Definition_05-12-2011.pdf

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Checklist Items:

- ☐ **Identify your experts:** Consider those who can work with you in the development of your ideas and plans. The work must include individuals with lived experience! Other experts in policy, health, or financing should also be strategically considered as guides, since they will eventually be potential owners. Think of traditional mental health partners, but also consider health policy centers, FQHC partners, emerging health homes, medical universities, hospital associations. These expert partners will help you build the rest of the work to follow.

- ☐ **Identify your target population:** Conceptually, who do you desire to be served with Peer Support Whole Health and Resiliency (PSWHR)? Targeting may be person-centric or may target a health delivery site, such as an emergency room or public health hub.

  - ☐ **Diagnostic/Functional:** The individuals who will be targeted to receive the service must be identified in a way that payers, provider agencies and practitioners alike can understand expectations. As you target health, you may want to take into account the co-occurrence of diabetes, high blood pressure, obesity, or other chronic health conditions. If you are considering Medicaid or HRSA reimbursement, you will need to consider how your local programs typically define these elements (for instance, DSM diagnosis or CPT diagnosis) and conform with that standard.

  - ☐ **Target Population Scope**: After defining the diagnostic and/or functional elements above, consider the potential volume estimates to provide support to those persons. Remember you should come back to this item when you finalize available funds. Your expert team may need to narrow your scope if there are limited funds available (e.g. limit to a pilot, to a specific geographic area, to a certain provider type, to a certain health site, OR narrow your diagnostic/functional criteria, etc.)

  - ☐ **Site Targeting**: Given your local opportunities, you may choose to focus on a facility first which may narrow your population to those who will frequent that site. You may consider partnering with a hospital association to hire a trained peer workforce in a high-use emergency room or partnering with an FQHC to use the peer workforce as guides for individuals who present at those sites with a health condition and a behavioral health issue. In these scenarios, the presenting site population is defining your target group and the peer workforce can be trained/oriented to work in that environment.

Checklist Items, continued:

- ☐ **Create a definition:** No matter your proposed framework, consider the structure of the existing policy so that your products are ultimately culturally acceptable (e.g. if most of the state agency definitions are 1-3 paragraphs in length, then limit your definition to this length). This should define the goals of the service and then define what will happen within the context of the service delivery. The provided SAMHSA definition is a solid base from which to begin.

- ☐ **Define Programmatic Requirements:** The definition above has to be operationalized in a way that purchasers and providers can "see" how it will work. With sensitivity to the local selected practice, consider these following elements:

  - ☐ **Staffing requirements**: Who can provide this service? Of course, individuals who self identify as having lived experience with a mental illness and/or an addiction are the practitioners, but other considerations such as credentialing and required training should be addressed. The peer staff must feel confident in their role supporting individuals in navigating health systems and creating and achieving health goals.

  - ☐ **Models of Service Delivery**: Will the service be done one-on-one or provided to groups? Will telephonic support or telemedicine be allowed? Will the peer professional work as an independent practitioner or be paired with a nurse or physician? Perhaps the peer will be a member of a multi-agency team which will span MH, SA, medical, and social services (Mauer, Druss, 2011).

  - ☐ **Interconnectivity**: The service ideally works with the identified person to build strong partnerships with those who will support wellness and recovery goals. Programmatic considerations should define expectations related to building trust with the person so that trusted consent is garnered. The following aspects should be considered programmatic elements:

    - **Formal Supports**: How the service receives referrals, refers to other services, and collaborates and communicates with other formal supporting partners, especially considering physicians, nurses, health homes, FQHCs, etc.

    - **Informal Supports**: How the service engages friends, family, and other informal networks in order to create a circle of support to accomplish wellness and recovery goals.

Checklist Items, continued:

- ❑ **Service Scope and Duration:** Your target population having been decided, what is the frequency of service contact and length of time you believe these individuals will need service? If Medicaid financing is being considered, generally a "Licensed Practitioner of the Healing Arts" (LPHA) must be utilized to determine how much and how often a service can be provided. LPHA is defined differently in different states, sometimes in law, but most often in policy. Be sure to know your local Medicaid expectations in defining this element. The best tools in determining service scope and duration with be:
    - Clear assessment
    - Person-Centered Planning
    - Good Relationship with LPHA

- ❑ **Documentation:** How will you guide practitioners of this service to document the interventions provided? Consider minimizing administrative burden while maximizing the elements needed for the notes to be effective to health and behavioral health professionals. Most states/agencies have documentation standards which can be a framework for your decisions; however, the peer practitioner should be prepared to document:
    - Person's basic status
    - Goals worked on during intervention (recovery plan-oriented)
    - Type of intervention
    - Results of intervention
    - Plans for next steps

☐ **Define Agency Requirements:** If you haven't already identified a specific environment in which to provide this service, you now must consider this: where are the natural provider hubs in which this service can thrive? If your state has Consumer-Operated organizations, will they be the best provider agencies? Also consider traditional behavioral health providers and other health hubs such as FQHCs, Health Homes, Case Management/Disease Management agencies, hospitals, etc.

☐ **Cost Analysis:** The state will have to consider its peer workforce qualifications and those associated costs (certification, additional health coaching training), local salaries, staff-to-person-served ratios, benefits, productive hours, and administrative costs in determining its estimates.

Checklist Items, continued:

☐ **Funding Mechanisms:** Your team must consider the current or potential mechanisms used for funding and financing behavioral health and/or health and wellness services. State Medicaid Plans, Waivers, Health Homes grants, and FQHCs are the most obvious mechanisms for supporting PSWHR. Additionally, there are broader health arrangements in which to embed the concepts or services. Accountable Care Organizations (ACOs), insurance exchanges, and managed care vendors will all be seeking solutions to supporting individuals with behavioral health issues and to address their overall health outcomes. Many state Medicaid authorities are challenged with how to engage individuals living with a mental illness or addiction in their disease management/health coaching programs and this service may create an opportunity outside of the traditional behavioral health service system. Depending on your local funding mechanisms and related opportunities, you may be considering a stand-alone service with a fee-for-service-unit rate, you may be selling the benefits of cost-efficacy in supporting pay-for-performance/outcomes, or you may be promoting a peer professional as a health coach. No matter the fund source, track your success, and then use your demonstrable evidence to leverage Medicaid in the future.

☐ **Demonstrate Outcomes:** Plan for outcomes monitoring from the onset of the service implementation. Consider this: When you provide a service to an individual, you always work from a recovery plan with goals and objectives, then you work with the individual to continually adapt and modify the plan. Craft similar goals for your implementation and be prepared to modify and improve your program model as you go. Document these modifications so that they may be replicable. Your initial approach does not have to sophisticated, but you should be prepared to provide interested parties with some evidence of success.

Finally, know the detail of these checklist elements. The completion of the work above will make you and your team experts in your plan. From this knowledge base, you can decide your advocacy positions and identify the partners who are your allies in supporting the implementation of the approach. As you begin your persuasive conversations around the implementation, continuously refine your pitch and share your outcomes. You are providing solutions to some of the most challenging engagement issues in healthcare, so be bold in your innovation, modify when necessary, and be successful!

Resources:

Whole Health, Wellness & Resiliency Peer Support Training Manual, published by the SAMHSA-HRSA Center for Integrated Health Solutions (www.CenterforIntegratedHealthSolutions.org), August 2011.

Morbidity and Mortality in People with Serious Mental Illness, 2006, Parks, et.al., http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

Measurement of Health Status for People with Serious Mental Illnesses, 2008, Parks, et.al., http://www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf

National Council Magazine, 2010, Whole Health Issue 3, ed. Dayak, http://www.thenationalcouncil.org/galleries/NCMagazine-gallery/NC%20Mag%20Whole%20Health%20Web-Email.pdf

SAMHSA-HRSA **Center for Integrated Health Solutions** website: http://www.thenationalcouncil.org/cs/center_for_integrated_health_solutions

Substance Abuse and Mental Health Services Administration's Recovery Support Services Definitions: ***"Relapse Prevention/Wellness Recovery Support,"***
http://www.samhsa.gov/grants/blockgrant/Relapse_Prevention_Wellness_Recovery_Support_Definition_05-12-2011.pdf

Substance Abuse and Mental Health Services Administration's **Screening, Brief Intervention, and Referral to Treatment (SBIRT),** http://www.samhsa.gov/prevention/sbirt/

"Designing a Person-Centered Healthcare Home for the Population with Serious Mental Illnesses," NASMHPD Research Institute, Mauer, Druss, 2009, http://www.thenationalcouncil.org/galleries/nc-live/MauerDruss%20NRI%20Final%204-21-09.pdf