Exploring the Impact of Peers in Mental Health and Substance Use Recovery

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Disclosures

- Was co-leader Reverse The Cycle program implementation at previous hospital employer
- Program was part of state grant and coordinated with the Mosaic Group
- Several slides are being presented with permission of Mosaic Group
- No funding or pay was received for work performed with Mosaic Group

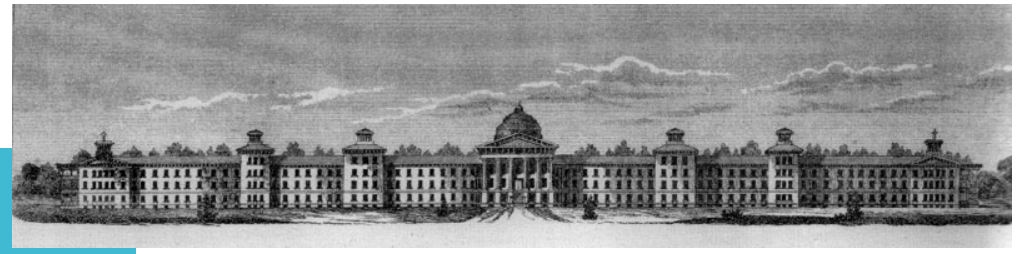
Short Description

While the term *peer support* is becoming more prevalent in the medical literature, the idea behind it has been around for decades. If we consider cancer support groups, caregiver organizations, or sponsors in Alcoholics Anonymous as examples, the idea of peer support is not new. A peer in this context is defined as *an individual with a lived experience* dealing with a particular condition or set of circumstances (e.g. bariatric surgery candidates or diabetic education group members). While a part of the social work field for decades, we are beginning to see the advantages of more directly incorporating peers into the medical setting. This presentation will specifically focus on the benefits of utilizing peer recovery coaches with lived experiences of mental health and/or substance use disorder in emergency department, hospital, and outpatient office settings.

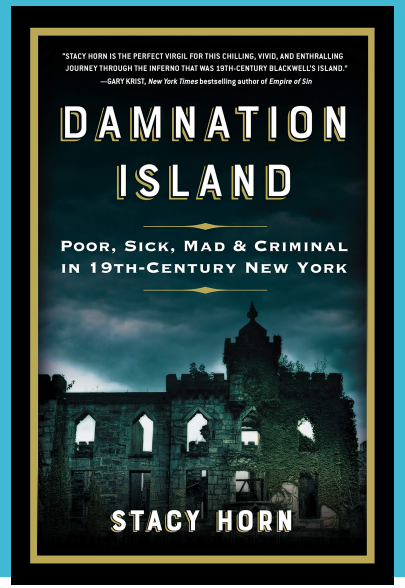
Learning objectives

- Explore data supporting peer interventions
- Understand the value of screening for mental health and substance use
- Examine how to incorporate peer services into existing patient work-flows
- Discuss how PAs can advocate for, incorporate, and support peer support services in a variety of settings

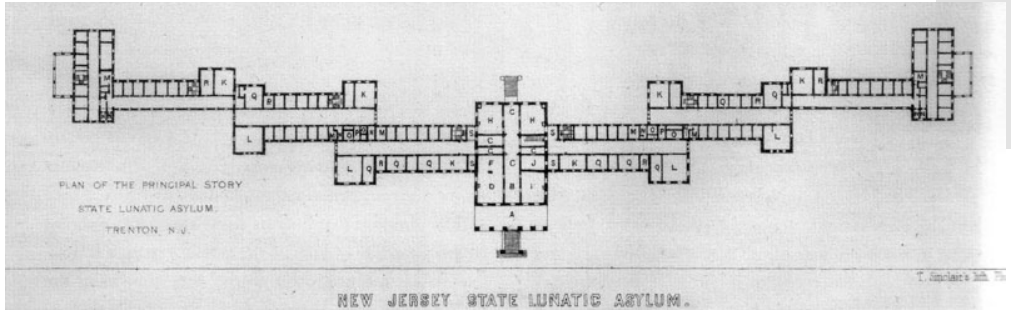
Some mental health history



Historical Context



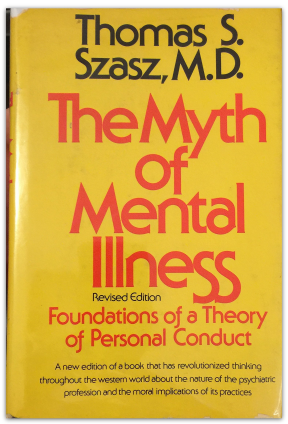
- Late 1700s/early 1800s – evolving approach to the treatment of mentally ill with asylum reform, "moral treatment"
  - Vincenzo Chiarugi (Italy)
  - Marguerite Pussin, Jean-Baptiste Pussin, Philippe Pinel (France)
  - William Tuke (England)
  - Benjamin Rusk, Dorothea Dix, Thomas Story Kirkbride (US)
- Focused on reducing restraints, healthy environment, better treatments
  - Often employed former patients [peers]
- Reforms rolled back with industrialization, biomedical approach, immigration/eugenics movement

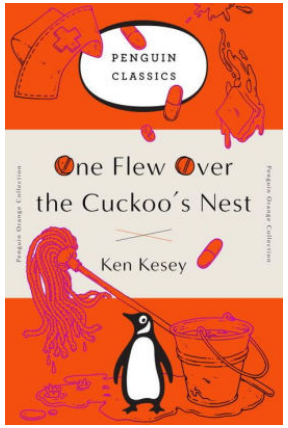


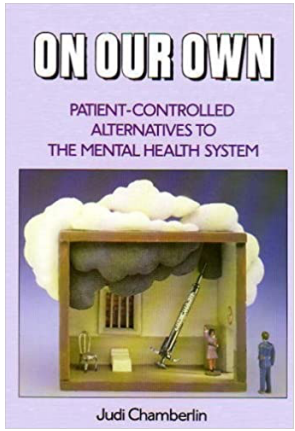
https://www.inaops.org/past-webinars https://mn.gov/mnddc/parallels/three/1.html
https://mn.gov/mnddc/parallels/index-part-one.html

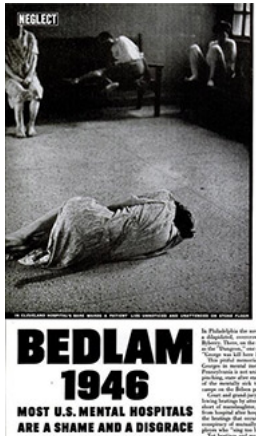
Historical Context

- 1940s-1970s:
  - Life Magazine exposé on care in asylums ("Bedlam")
  - 3rd force in psychology- Humanistic Approach
    - More client (patient) focused, less authoritative/expert role
  - Antipsychiatry movement
    - Coercion/forced treatment
    - Overuse of lobotomies
    - Recognition of tardive dyskinesia
  - Civil rights movement
    - Increasing focus on racism, sexual/gender issues, socioeconomic forces as background of interpretation of "mental illness"









https://www.pbs.org/wgbh/americanexperience/features/lobotomist-bedlam-1946/ https://bit.ly/3nUYb60
https://www.simplypsychology.org/humanistic.html

Historical Context

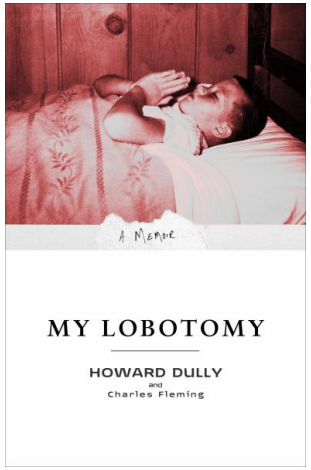
- 1960s-1980s
  - Federal commission report "Action on Mental Health"
  - Community mental health centers receive increased funding
  - Deinstitutionalization across the country as state run asylums were defunded
    - Conversely increases in incarceration rates of those with mental illness
  - More therapeutic communities: residential programs, partial hospitalization ("day programs")
    - National Alliance on Mental Illness formed by families of individuals with MH issues
  - Beginnings of the Recovery Movement

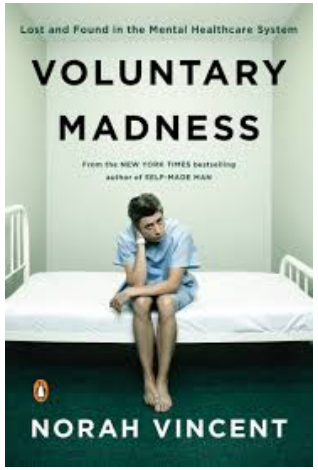
https://www.thebalance.com/deinstitutionalization-3306067
https://babel.hathitrust.org/cgi/pt?id=mdp.39015012563444&view=1up&seq=7
https://mn.gov/mnddc/parallels/index-part-one.html

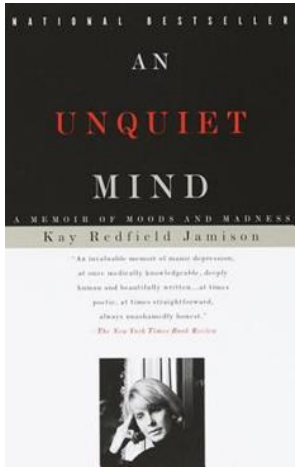
Historical Context

- 1990s to Today
  - Americans with Disability Act, Affordable Care Act
  - Continued honesty with personal MH struggles
  - Integrated Care movement
    - Incorporating counselor/social work in primary care offices
    - Now also incorporating PCP in behavioral health settings
    - Expansion of school-based health centers

- Peer support groups in medical world: cancer, diabetes, bariatric, caregivers, etc.
- Also present in VA system, criminal justice







https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0153

Peers in Substance Use Support

- "Officially" present for much longer than in medical world
- Temperance societies often revolved around recovery from alcohol use
  - First formal society formed in the US in 1820s
- AA founded 1935
- NA founded 1953

https://www.aa.org/pages/en_us/historical-data-the-birth-of-aa-and-its-growth-in-the-uscanada
http://www.williamwhitepapers.com/pr/2004PeerRecoverySupportServices.pdf ``

What is a "peer"?

- Peer support specialist
- Peer recovery coach
- Peer recovery specialist
- Peer educator
- Peer worker

Some overlap with Community Health Workers and Outreach Specialists

- Per SAMHSA:

  Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
https://www.commongroundprogram.com/blog/peer-specialists-are-not-clinicians

What can peers do?

- Work one-on-one with clients as mentor/coach
  - Develop Psychiatric Advanced Directives
  - Develop Wellness Recovery Action Plans (WRAPs)
  - Help clients self-advocate
- Staff residential facilities
- Community outreach programs
- Be part of Crisis teams
- Run support groups
- Connect with community resources/navigate systems

https://www.mhanational.org/what-peer

Tangent

Psychiatric Advanced Directives

- Outlines preferred treatments
  - Preferred de-escalation techniques
  - Avoid certain facilities
  - Avoid certain medications
- Can be a legal document
- Identifies health proxy in times of mental crisis
- National Resource Center on Psychiatric Advanced Directives

https://www.nrc-pad.org/

Wellness Recovery Action Plans

- Wellness toolbox
  - Coping skills
  - "Personal medicine"
- Daily plan
- Stressors/triggers
- Warning signs
- Crisis plan
- There's an app for that!

https://mentalhealthrecovery.com/

Peer Credential Requirements

- Each state has specific peer support credentials
- Usually:
  - High school diploma or GED
  - Sustained recovery, 2+years (MH or SUD)
  - Training program followed by clinical work as peer, sometimes with direct supervision requirements
    - This is opportunity for PAs- to become a certified peer supervisor
  - Continuing education credit
  - Written exam in some states

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University of Michigan Behavioral Health Workforce Research Center. "Scopes of practice and reimbursement patterns of addiction counselors, community health workers, and peer recovery specialists in the behavioral health workforce". Ann Arbor, MI; UMSPH; 2018. Reprinted with permission. https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/06/Y3-FA3-P1-SOP-Full-Report-Updated-6.5.19.pdf

How common are peer services?

- 25% of all mental health facilities in US offer peer services
  - Most often found in community mental health facilities, least likely in residential or PHP
- 56% of SUD treatment facilities have peers
  - Sober housing most likely to have peers on staff

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University of Michigan Behavioral Health Workforce Research Center. "National analysis of peer support providers: Practice settings, requirements, roles, and reimbursement." Policy Brief. Ann Arbor, MI: UMSPH; 2019. Reprinted with permission. https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Brief-Report.pdf

Where are peer services?

University of Michigan Behavioral Health Workforce Research Center. "National analysis of peer support providers: Practice settings, requirements, roles, and reimbursement." Ann Arbor, MI: UMSPH; 2019. Reprinted with permission. https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf

Screening 101

The Case for Screening

- As many as 40 percent of all patients seen in primary care settings have a mental illness.
- 27 percent of Americans will suffer from a substance use disorder during their lifetime.
- 80 percent of patients with behavioral health concerns present in ED or primary care clinics.
- Approximately 67 percent of patients with behavioral health disorders do not receive the care they need.
- 68 percent of adults with mental disorders have comorbid chronic health disorders, and 29 percent of adults with chronic health disorders have mental health disorders.

Slide adapted from following with open-source permission https://www.thenationalcouncil.org/integrated-health-coe/resources/

Use your waiting room

- Screening tools built into your patient portal, intake kiosk/tablets, verbal triage, or good old paper
  - Depression
    - PHQ 2 or 9, Edinburgh Postnatal, Geriatric Depression Scale
  - Suicide *Joint Commission requirement*
    - ASQ, Columbia- Suicide (C-SSRS)
  - AOD Use
    - DAST, AUDIT, CAGE, ASSIST
  - Smoking
    - 5 A's (Ask, Advise, Assess, Assist, Arrange)
- Provider documents they reviewed the screening tools (if neg.) or addressed/referred for care (if pos.)
  - Just like vital signs

Depression https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/depression.html https://www.aafp.org/afp/2018/1015/p508.html
Suicide JHACO https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/
AOD https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf Tobacco https://www.ahrq.gov/prevention/guidelines/tobacco/5steps.html

SBIRT

- Screening, Brief Intervention, Referral to Treatment
  - New **gold** standard
- Screening
  - May use any screening tool
- Brief Intervention
  - Discussing the results
  - Planting the seed for further discussion
- Refer for services or supports
  - Can just be community supports or comprehensive program
- This is perfect opportunity for peers to be incorporated into patient flow

Agerwala and McCance-Katz. "Integrating Screening, Brief Intervention, and Referral to Treatment (SBIRT) into Clinical Practice Settings: A Brief Review" 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3801194/

SBIRT Effectiveness Studies

- Reduced health care costs
  - For each $1 spent on SBIRT = Save $3.81-$5.60
    - Reduced ED visits 20%
    - Reduced hospitalizations 37%
    - Reduced non-fatal injuries 33%
    - Reduced car crashes 50%
  - Reduced severity of drug & alcohol use
  - Reduced arrests 46%

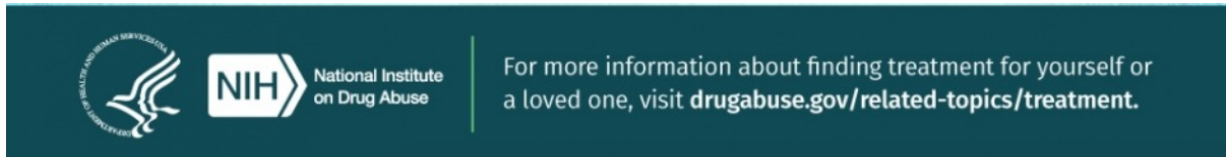
- Newer studies show **savings of $2,074 to $6,504** per patient per YEAR after conducting SBIRT in the ED https://urbn.is/2MS5SoN

Data from SAMHSA-HRSA Center for Integrated Health Solutions SBIRT Fact Sheet
Slide reprinted with permission from Mosaic Group

Engaging in Treatment

What are the barriers to getting treatment for co-occurring disorders?

*Co-occurring disorders means the person has both a mental health and a substance use disorder



Among adults with co-occurring disorders who did not receive substance use care, their reasons for not receiving care were:

Incorporating Peers into Existing Workflows: **Office**

- Referral only option vs. in office visits
  - Create referral "order" in EMR
- Integrated care model– "warm handoff" – see provider first, then peer
- Screening model – peer assists with questions, prepares client for visit with provider
- Stand alone appointment with peer
  - Doesn't have to be limited to the office
  - But recommend public spaces

Peers in Office: Example

- Outpatient community psych
- Previously assisted with pre-appointment screening
  - Used a program called *CommonGround* created by Pat Deegan
    https://www.commongroundprogram.com/software
- Now work with clients in community setting
  - Assist with treatment plans
    - Education, Vocational, Social, Self-Maintainence

Incorporating Peers into Existing Workflows: **Emergency Department**

- Nurses or providers screen for substance use
- All positive screens seen by peer, preferably while in the ED
  - All + screens have phone or email contact within 24hrs of discharge
- Assess desire to engage in treatment services
- Start the referral process
- Peers can facilitate discharge from ED directly to treatment program
- Work with case management/psych services to help frequent flyers

Incorporating Peers into Existing Workflows: **Hospital**

- Similar to ED- work with patients admitted specifically for MH/SUD related complaints and those that screen positive on admission
- Role for SUD screening pre-op
  - Affects anesthesia but also post op recovery/risk of withdrawal
- Labor and Delivery
  - Lower threshold for positive screen – any use of any substance during pregnancy (e.g. 'medical marijuana')
  - Pregnant patients are extremely motivated to get sober, but also face significant hurdles and higher risk of violence
  - Point of intervention for any patient presenting with overdose/intoxication and +HCG
  - Pregnant specific screening tools exist
    - 4P's Plus, SURP-P, NIDA ASSIST

https://bit.ly/3afqVDl
https://journals.lww.com/greenjournal/Fulltext/2019/05000/Accuracy_of_Three_Screening_Tools_for_Prenatal.15.aspx

But does it actually work?

Supervision? But I don't know anything about mental health!

You know the clinical side of things!

- Can help manage the sequelae of diseases
- Explain why patients are/are not candidates for certain treatments
- "Medical clearance" to enter programs
- Help with detox protocols and buprenorphine induction
- Program champion
  - Get your colleagues and nursing staff on board
  - Works really well to have co-supervisors, one behavioral health background and one medical

Note: each state has its own requirements for what defines official peer supervisor

SAMHSA Supervisor resource
https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/guidelines-peer-supervision-4-ppt-cp5.pdf

What is integrated care?

"Integrated health care, often referred to as interprofessional health care, is an approach characterized by a high degree of collaboration and communication among health professionals. What makes integrated health care unique is the sharing of information among team members related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological and social needs of the patient. The interprofessional health care team includes a diverse group of members (e.g., physicians, nurses, psychologists and other health professionals), depending on the needs of the patient."

American Psychological Association

https://www.apa.org/health/integrated-health-care

What is Integrated Care?

https://www.cfha.net/page/IntegratedCare

Where is Integrated Care?

- 44% of PCPs in a survey were co-located with BH provider
- Pediatricians, OBGYN, Internal Medicine most likely to be co-located
- Larger the practice size, more likely to have BH provider

https://www.behavioralhealthworkforce.org/wp-content/uploads/2018/12/NPI-Brief-Report_Final.pdf
https://www.cfha.net/page/IntegratedCare

What exactly is a "warm hand-off"?

- The direct 'transfer' of a patient from one person to another in front of the patient/family
- While in theory is "gold standard", but evidence is actually limited with regards to behavioral health hand-offs
- Important to **ASK THE PERSON FIRST**

https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html
https://pubmed.ncbi.nlm.nih.gov/33392929/ https://www.annfammed.org/content/16/4/346.long
https://www.integratedcarenews.com/2018/the-warm-handoff-turn-up-the-research-heat/

Protecting Your Peers

- Different type of background, training, focus than majority of those in clinical world
  - Larger focus on hope and human connection, unconditional positive regard
  - Less focus on bottom line, patients per hour
- Need to be well established in their own recovery
- Watch for burnout, triggers, vicarious trauma
- Encourage self-care and good boundaries

All the things we should already be doing for ourselves!

https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/guidelines-peer-supervision-4-ppt-cp5.pdf

But I got to get paid!

Reimbursement

- Always hard to prove benefit of saving money
- Most states reimburse peer support services under Medicaid
  - But reimbursement is primarily made to the organization (1)
- Peer support services often have its own distinct code in State Medicaid programs.
  - University of Michigan survey found on average, a peer recovery specialist was reimbursed **$12.98 per unit (15 minutes)** of peer support services (2) – *more than minimum wage!*
- Another survey by a market research company found rates of **$1.94 to $24.36** under state Medicaid fee-for-service programs using CPT code H0038 which is 15min of intervention (3)
  - But other codes exist and may have better reimbursement

1- https://www.gao.gov/assets/710/708685.pdf 3- https://bit.ly/3aBRiT8
2- https://www.behavioralhealthworkforce.org/wp-content/uploads/2018/12/Y3-FA3-P1-SOP-Reimb-AC-CHW-Peers_Brief-Report.pdf

Reimbursement Codes for BH/SUD Interventions

- Nicotine
  - 99406: 3-10min
  - 99507: smoking cessation >10min
  - $12-$26
- SBIRT
  - G2011: 5-14min
  - G0396/99408 15-30min
  - G0397/99409 >30min
  - $17-$65
- Bundled payment for Collaborative Care Model, paid based on time spent PER MONTH
  - 99492-99494, starting at 70min/month
  - 99484, 20min/month
  - G2214, 30min/month
  - Paid $31-$157
- Modifier 25

- You can get paid for screening even without an intervention being necessary
- You can get paid for multiple screening tools being done on the same day

SBIRT CMS handout https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf
https://www.aafp.org/fpm/2017/1100/fpm20171100p25.pdf https://www.aafp.org/fpm/2017/0500/p12.html
CoCM bundled payments https://aims.uw.edu/resource-library/cms-collaborative-care-payment-summary-sheet
https://www.behavioralhealthworkforce.org/wp-content/uploads/2020/01/Y4-P7-Full-Report.pdf

What to document

Specific to nicotine use

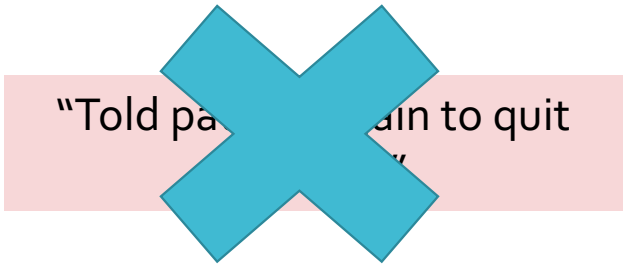
- Patient's willingness to attempt to quit
- What was discussed during counseling
- Amount of time spent counseling
- Tobacco use
- Advice to quit and impact of smoking provided to patient
- Methods and skills suggested to support cessation
- Medication management
- Setting a quit date with the patient
- Follow-up arranged
- Resources made available to the patient
- Must include ICD code to correlate with cessation CPT code, e.g. Nicotine Dependence
- Caps on number of times this will be reimbursed per year

https://www.lung.org/getmedia/08ed3536-6bab-48a6-a4e4-e6dbccaea024/billing-guide-for-tobacco-1.pdf.pdf
https://tobaccofreeny.org/images/hsi/Resources/Documenting-Coding-Billing-For-Tobacco-Dependence-Treatment.pdf
https://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/ehr-tobacco-cessation.pdf

What to document

"A 67-year-old male Medicare patient presents with exacerbated COPD on oxygen. This patient continues to smoke one pack of cigarettes per day after several failed attempts at quitting. Approximately 15 minutes were spent counseling the patient in cessation techniques. He understands continuing to smoke could lead to stroke and death. The benefits of stopping were also presented to him. The patient has verbalized his desire to "give it another try." He has set his own goal of 30 days to be completely smoke-free. We will follow up in two weeks to check progress."

Example from https://www.aapc.com/blog/35703-get-paid-for-smoking-cessation/



"Patient uses tobacco products. Patient was counseled for greater than 3 minutes regarding the risks of use. Patient was offered follow up resources for cessation. Patient responded well to the counseling."

https://www.lung.org/getmedia/08ed3536-6bab-48a6-a4e4-e6dbccaea024/billing-guide-for-tobacco-1.pdf.pdf
https://tobaccofreeny.org/images/hsi/Resources/Documenting-Coding-Billing-For-Tobacco-Dependence-Treatment.pdf
https://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/ehr-tobacco-cessation.pdf

Other things to make peer programs successful

- Partner with health department
- Community programs
- Integrated care – PCP in BH office, school-based health care

Comprehensive Harm Reduction Strategies

- Point of care HIV/Hep C
- Pregnancy testing, access to contraception
  - Need to watch for contraceptive coercion
- Overdose Fatality Review Teams
- Mental health services
- Primary Care
- Naloxone distribution
- Needle exchange
- Safe injection sites
- MAT/MOUD
- Education
- Childcare
- Food Pantry
- Legal services/ "drug court"
- Shelter/housing
- Utility assistance
- Transportation
- Job placement
- Dental services
- Integrated care settings

All areas that peers can be involved

What can the PA do?

- Get Mental Health First Aid trained – and become a trainer!
  - https://www.mentalhealthfirstaid.org/
- Look at the PA Foundation Mental Health and Substance Use Disorder programs
  - https://pa-foundation.org/
- Complete your MAT waiver- the training is FREE and extremely valuable!
  - ASAM https://elearning.asam.org/products/24-hour-waiver-training-aapa
  - PCSS https://pcssnow.org/medications-for-addiction-treatment/waiver-training-for-pas/
- Advocate for integrated care services in your practice/health system
  - CFHA https://www.cfha.net/
  - SAMHSA-HRSA https://www.samhsa.gov/integrated-health-solutions
- **Become a certified peer support supervisor!**

Additional Resources

- https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
- http://peersforprogress.org/learn-about-peer-support/science-behind-peer-support/
- https://www.naadac.org/ncprss
- https://www.commongroundprogram.com/software
- https://www.mhanational.org/center-peer-support
- https://www.inaops.org/
- https://www.behavioralhealthworkforce.org/
- https://www.thenationalcouncil.org/integrated-health-coe/

Take Home Points

- Implementing mental health and substance use screening can be done with limited impact on patient flow
- Peer specialists can be integrated into variety of healthcare settings with significant impact on health outcomes
- Reimbursement rates can make the use of peers a budget neutral addition or even result increased revenue

Questions?

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