Level-of-Care Criteria for Peer Support Services: A Best-Practice Guide

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Peer support services (PSS) are an expanding part of the continuum of care provided for behavioral health conditions. These services have been deemed an evidence-based reimbursable model of care by the Centers for Medicare and Medicaid Services. States, counties, employers, and health plans are increasingly covering PSS in benefit plans. Controlled and experimental studies are building the evidence base for these services. Medicaid and the states have not developed level-of-care or medical necessity criteria for PSS, even though these criteria are standards for determining coverage and reimbursement. This review of emerging level-of-care criteria for PSS provides a framework for the further development of these resources. (*Psychiatric Services* in Advance, October 15, 2013; doi: 10.1176/appi.ps.201300277)

Peer support services (PSS) include a range of activities and services that are delivered in both clinical settings and the community. The scope of these services includes peer support to foster encouragement of personal responsibility and self-determination, focus on health and wellness, and support engagement and communication with providers and systems of care (1). Three types of PSS roles are generally described (2); they include distinct services and tasks delivered by the peer, services provided by the peer as part of a delivery team that may also include nonpeers, and traditional services that are delivered in a way that is informed by the personal recovery experience of the peer specialist.

Research shows that PSS promotes empowerment and self-esteem, self-management, engagement, and social inclusion and improves the social networks of consumers who receive these services (3). A randomized controlled trial found that participants in a peer-led Wellness Recovery Action Plan program showed greater reductions in symptoms of depression and anxiety than those who received usual treatment (4). In addition, peer-delivered services through the Health and Recovery Peer Program (5) led to greater participant activation, medication adherence, and involvement in primary care, as well as improved quality of life. Studies of clinical outcomes of PSS have also shown that involvement of a peer mentor (peer bridger services) results in fewer readmissions and overall hospital days (6). Use of an online recovery planning tool led to better participant engagement and retention when peer coaches were provided (7). In support of peer-delivered services, the research evidence qualifies as level 1b ("evidence obtained by at least one randomized controlled trial") on the basis of the Agency for Healthcare Research and Quality guidelines (8).

Twenty-five core tenets or pillars of PSS have been developed and include key areas of education, certification, employment, professionalism, and community advocacy (9). Training and certification for PSS in adult mental health settings are largely determined at the state level and based on designated curriculums, competencies, and testing requirements. At the national level, the Department of Veterans Affairs is currently establishing a standardized training and certification process.

Expanding coverage for PSS

In 2007, Medicaid deemed PSS an evidence-based practice and reimbursable in states that choose to build these services into their state plan (10). Medicaid, state-funded behavioral health care, and health home pilot projects are increasingly requiring PSS as part of their contracts (11). Insurance companies and managed care organizations are embracing PSS and formally incorporating these services into their networks of covered behavioral health care services. However, knowledge is limited in regard to when and how these services are best deployed, and the lack of national standards or licensing makes it difficult to credential and establish networks of peer providers. Level-of-care guidelines must be established for PSS to be consistent with best practices for other clinical services.

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Level-of-care guidelines are the cornerstone of evidence-based care management. Insurers and health management companies have standardized procedures for the development of medical management and utilization review criteria. The establishment of these policies is based on a review of clinical evidence and evaluation of the outcomes of the services provided. These best-practice standards determine the ideal level of care over the course of treatment for a given condition. On the basis of these expanding coverage opportunities and care management requirements for PSS, Optum, a leading provider of specialty health solutions that serve the general medical and mental health needs of both individuals and organizations, has successfully established a set of level-of-care criteria to guide treatment planning, care management, and evaluation of outcomes of these services.

Developing level-of-care guidelines for PSS

The insurance industry standards for the development of level-of-care guidelines include defining the range of services, reviewing the evidence for these services, and establishing coverage criteria for reviewing and approving care. There has been an increasing emphasis on the transparency of review criteria and on open dissemination of these criteria to both clinicians and consumers. For PSS, these criteria have not been previously established.

Guidelines for PSS reflect the intent to improve the experiences of people receiving care for mental health and substance use conditions through the development of tools and resources to support well-being, community living, and recovery. These evidence-based tools help determine when PSS are the appropriate service—that is, in line with a person's needs, preferences, and broader recovery and resiliency goals. As tools for improving the system of care, PSS guidelines serve as best-practice standards for a range of services that promote well-being but which have been inconsistently defined, delivered, and covered.

To create level-of-care criteria for PSS, an Optum workgroup comprising clinical professionals and consumer representatives reviewed available research findings and guidance on best practices from governmental sources. The group was also responsible for synthesizing evidence-based findings into level-of-care criteria and providing a consensus opinion when the evidence base was lacking.

Four level-of-care criteria sets have been established by Optum and include guidelines for peer-to-peer services and supports, peer bridger services, family-to-family support services, and family peer bridger and navigator services. These level-of-care criteria include a review of the applicability of the services, a description of the services, a review of the scientific and other evidence, a review of governmental services, indications for coverage, applicable procedure codes, and references. A synopsis of the guidelines for peer bridger services is provided below as an illustration of these best-practice tools. [Full additional guidelines and references are available in an online supplement to this column.] In each state, Optum works within the state's established guidelines for training and certification in the development of peer provider networks.

Level-of-care guidelines for peer bridger services

This synopsis includes excerpts from Optum's description of service and indications for coverage.

Description

Peer bridger services is a form of community support service in which a certified peer specialist (CPS) assists an adult member who is recovering from a severe and persistent mental illness with engaging in treatment and other community support services. Peer bridger services are built on a relationship of trust developed between a CPS and the member. Peer bridger services complement the member's behavioral health treatment services and may be delivered while the member is receiving behavioral health treatment or in advance of the start of behavioral health treatment in order to facilitate engagement in care. Peer bridger services vary in intensity, frequency, and duration in order to support the member's ability to utilize behavioral health services, manage psychosocial challenges, and realize broader recovery goals.

Indications for coverage

To qualify for PSS coverage, the member must have a severe and persistent behavioral health condition. Any one of the following criteria must also be met. The member has significant difficulty consistently and independently accessing or utilizing ambulatory behavioral health care or medical care. For example, the member relies primarily on emergency room services or has had two or more inpatient admissions in the last year. The member is either being discharged from a hospital or a facility-based program or being released from incarceration. The member has significant difficulty consistently and independently managing age-appropriate activities of daily living, including finances, hygiene, nutrition and meal preparation, home maintenance, child care, or legal, housing, transportation, and other community service needs. The member has significant difficulty maintaining employment or meeting educational goals. The member lives in an unsafe environment or impermanent housing. The member does not have family or social supports, or the family or social supports cannot help the member utilize care or manage his or her behavioral health condition. Both of the following criteria must also be met. The member is not at imminent risk of serious harm to self or others. The member has a treatment plan that adequately addresses his or her behavioral health and co-occurring general medical conditions.

The CPS begins the process of contacting the member before the member's discharge from a hospital or other facility-based program or within 24 hours of referral to peer bridger services. The CPS confirms that the member wants peer bridger services. The CPS and the member complete an initial needs assessment. Within the first three visits the following steps occur. The CPS and the member complete a recovery plan. The plan

includes a description of the member's short- and long-term goals, the time frames for meeting each goal, and the interventions that will help the member to meet the goals. With the member's documented consent, peer bridger services staff coordinate the member's family or social supports, behavioral health providers other than the primary behavioral health provider, medical providers, and agencies and other programs with which the member has been involved. The CPS and member collaborate to formally review the recovery plan every six months, and revisions are made whenever there are significant changes in the member's condition, needs, or preferences.

The CPS and member develop a plan to end peer bridger services when any of the following occur. The CPS, member, and the member's behavioral health provider agree that the member has achieved his or her short- and long-term goals, the member is moving outside the geographic area served, or the member requests to end peer bridger services even though the CPS and behavioral health provider recommend that services be continued. The CPS coordinates the end of peer bridger services with the member's primary behavioral health provider. The CPS compiles a list of peer support groups and activities within the member's geographic area. The CPS also provides the member with information about resuming services should the need arise.

Best-practice examples

A range of best-practice PSS programs have been developed by Optum in partnership with clinical service providers and consumer-run organizations. These services are incorporated into the claims system and are authorized and paid alongside other traditional services. Peer bridger programs (12), as described above, have been developed to provide peer services for individuals transitioning between hospital settings and the community. Early evaluation of Optum's programs suggests a decrease in average number of acute hospital days.

In Wisconsin, Optum's Peer Bridger Program, which is conducted in partnership with the Grassroots Empowerment Project, showed a 30% reduction in inpatient days, as well as positive outcomes on self-reported measures of quality of life, recovery, hope, social support, and mental health confidence. Focus groups conducted with program participants identified several subjective qualities of the peer relationship that may have contributed to these outcomes, including fostering the development of personal goals in the wake of difficulties, practical support from peers in advocating for issues or locating services, appreciation for having someone to talk to who genuinely cares and is willing to listen, and peer specialists' skillful balancing of friendship and structured support.

Conclusions

PSS represent a best-practice model of care for promoting hope and recovery, improved self-esteem and self-care, and increased resiliency and well-being. As these services expand and coverage requirements grow, these services require the same level of scrutiny and rigor as other types of care, including ongoing evaluation of effectiveness and of protocols and criteria for their use. The level-of-care guidelines presented here can serve as a framework for other organizations. Transparency in the development and dissemination of these guidelines will help to ensure the ongoing best-practice deployment of PSS across mental health, addictions, and integrated care.

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