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BEGIN TRANSCRIPT:

LARRY FRICKS: Hannah, go ahead and start.

HANNAH MASON: Good afternoon and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions national webinar, "The Role of Peer Providers in Integrated Health." My name is Hannah Mason and I, along with Larry Fricks, will serve as your moderator. As you may know, CIHS promotes the development of integrated primary and behavioral healthcare services, to better adjust to needs of individuals with mental health and substance use conditions. The national webinar is designed to help providers integrate care. The center posts practical resources and tools to the CIHS website, provides direct phone consultation to providers and stakeholders groups, and works directly with SAMHSA's primary behavioral healthcare integration grantees and personal fund and safety net providers. [00:01:11]

Slides for today's webinar are available on the CIHS website. The key points from today's webinar are to analyze randomized trial outcomes, showing significant impact on improving health, identified strengths peer providers bring to integrated health programs, for system transformation, and to learn important roles peer providers are trained to deliver. After we go over a few logistical issues, Larry Fricks will introduce today's presenters.

Before we begin, during today's presentation, your slides will automatically be synchronized with the audio. You will not need to flip any slides to follow along. You will listen to audio through your computer speakers, so please make sure they are on and the volume is up. To download the presentation slides, click the dropdown menu labeled Event Resources, on the bottom left of your screen. If you lose audio at any time, please feel free to refresh your player by clicking the double-click arrows located on your volume slider. You may submit questions to the speakers at any time during the presentation by typing a question into the ask a question box in the lower left portion of your player. If you need further technical assistance, please click on the question mark button in the upper right corner of your player, to see frequently asked questions and contacts for tech support as needed. [00:02:49]

Lastly, please take a moment to provide your feedback by completing the short survey at the end of the webinar. A recording will be available on the CIHS website shortly following today's

webinar. I would now like to turn it over to Larry Fricks, the Deputy Director of the SAMHSA-HRSA Center for Integrated Health Solutions.

LARRY FRICKS: Thank you, Hannah, and thank you everyone for joining us today. In setting the stage, the field of behavioral health was forever transformed in 2007, when the centers for Medicare and Medicaid services proclaimed peer support services as an evidence based model of care, and sent guidelines to states on how to bill for services delivered by peer providers assisting others with their recovery from mental illness and substance use disorders. Peer providers are the first workforce to emerge after national promotion of a vision of recovery, highlighted in the 2003 president's commission report on mental health, focusing on what's strong and what's wrong. Peer providers use their lived experience of recovery and skills learned in training, to activate in others, outcomes of recovery self-management. Examples of these skills include sharing your recovery story, combating negative self-talk, problem solving, overcoming fears, effective listening, linking to clinical and community supports, facilitating recovery groups, person centered planning and goal setting. Research published in 2008 by Eiken and Campbell, showed peer services resulted in reduced hospitalizations, reduced use of crisis services, improved symptoms, larger social networks, improved quality of life, and strengthening the recovery of people providing the services. [00:04:43]

Now, with healthcare reform driving health integration, mounting research, like you will hear about today, is showing that peer providers, often called health and wellness coaches and navigators, are emerging as highly effective in activation of self-management for outcomes of whole health and resiliency. Built on skills taught peer providers to support behavioral health recovery, in integrated health there's a shift to the whole person in recovery. Adding mind, body medicine practices, like stress management, restful sleep, healthy eating, physical activity, self-system navigation, shared decision making, providing ongoing social and emotional support, and engaging in health screens to promote prevention and longevity.

On the health side, there is already significant research, like recent studies led by Judith Hibbard, that health self-management results in increased treatment efficacy and cost savings. The Stanford chronic disease self-management program is an evidence based practice and delivered nationally for people, has successfully managed chronic health conditions. With healthcare reform requiring delivery systems to assume greater responsibility for health outcomes and cost, there is increasing focus on patient centered care and activating self-management skills that peer led interventions can deliver. Growing national recognition of this critical role of self-management to promote whole health and resiliency resulted in creating a federally funded peer delivered training called Whole Health Action Management, WHAM, developed by the SAMHSA-HRSA Center for Integrated Health Solutions, operated by the National Council for Behavioral Health. [00:06:30]

Now, it's my great honor to introduce a dear friend and a hero to many of us, Paolo del Vecchio, to give a welcome from SAMHSA. Paolo has his masters in social work. He is the Director of the Substance Abuse and Mental Health Service Administration, SAMHSA, Center for Mental Health Services, CMHS. SAMHSA is the lead federal agency designed to reduce the impact of substance abuse and mental illness on America's communities. Previously, Paolo was the CMHS Associate Director for Consumer Affairs, where he managed SAMHSA's precedent setting

activities and addressing consumer participation and education, issues of discrimination and stigma, consumer rights, wellness, recovery, trauma and others. Paolo was the first consumer affairs specialist, hired in 1995 by SAMHSA. In this capacity, he promoted consumer participation in all aspects of the center's policies and operations, ranging from public education to developing evidence based practices, to address the needs of persons with mental illnesses. Those efforts including initiating historic dialogue meetings between consumers, peers and practitioners, regional peer meetings, inclusion efforts, training programs, and grant development. His remarkable life inspires all of us. Thanks for joining us, Paolo. [00:07:58]

PAOLO DEL VECCHIO: Thank you, Larry, and greetings to everyone. I want to say I'm thrilled to welcome everyone to this webinar today on the role of peer providers in integrated health. SAMHSA, we're very pleased to partner with our colleagues at HRSA and National Council on Behavioral Health, on the Center for Integrated Health Solutions, to work on this vital mission to promote health and wellness, looking at issues such as healthcare integration, holistic health, the physical, mental, behavioral, that individuals can recover and live full and meaningful lives. I thank all the presenters as well, for joining us today, for making a difference. Applaud all of you on this call for the work you do every day to help those of us with behavioral health problems.

What strikes me as so exciting about this particular webinar is the intersection of the evidence based practice of peer support and applying that to whole health, the essential need to address whole health. I don't need to tell folks on the phone today, but the key critical importance of this work in terms of addressing whole health, addressing issues such as the high rates of early mortality, the high rates of comorbid health conditions like diabetes, obesity and other issues, that we are dying far too young, and so the essential importance of this work cannot be understated. Larry said peer support is an evidence based practice. We know from research that we're going to hear today, and others, that peers providing support to other peers are effective, issues of outreach and engagement into services, reduced hospitalization rates, higher rates of well-being, ultimately helping people on their journeys of recovery. [0010:03]

SAMHSA, of course we have a long history of supporting peer support and the peer workforce. Thirty years ago, SAMHSA then was part of the National Institute of Mental Health's initial community support program grants, were to look at consumer case management projects; one of the early forerunners in terms of looking at peers as providers. Of course in the '90s, we helped to support the consumer operated services program, a multi-site program to look at the efficacy of consumer operated services that again demonstrated the ability of peers to produce outcomes like wellness, and help to identify essential ingredients that go into peer operated services. We've really seen an explosion in terms of peer workforce over the past ten years, and that's certainly thanks to Larry and many others that are on this call today, and others out there in states and communities, and really, the emergence of a new workforce in behavioral health, where we're seeing peers working in so many settings, from community treatment teams to hospital settings to within peer organizations, from youth to older adults, family members, mental health, addictions, across the board. Criminal justice settings, in housing, employment programs, and now, looking at issues of whole health action management and wellness. [00:11:41]

Two-thousand and seven, SAMHSA launched a wellness initiative to address issues of premature mortality and comorbidity, again working with peer organizations, providers and others, to look at how we can address the preventable medical conditions and modifiable risk behaviors that go into early mortality. We know that peers are powerful messengers, help stem the tide of early mortality and help to show the way and provide that essential ingredient of hope. Who can better carry the message than peers themselves, who in recovery discovered that you don't have to accept a life of smoking, poor nutrition and inaction, and that medical illnesses should not be ignored or overlooked when trying to treat behavioral health disorders.

Recently, we've partnered with the CDC's Million Hearts campaign, a national initiative to prevent a million heart attacks and strokes by 2017, given we know the critical role that cardiovascular health plays in terms of early mortality. We also established a national Wellness Week. In 2013, we celebrated our second annual wellness week, where we had more than 150 wellness activities around the country and more than a hundred organizations in 24 states, including Washington, D.C., and Guam. Plans are underway for Wellness Week 2014, which will happen during the week of September the 15th. [00:13:16]

I have to also mention our work in terms of looking at primary and behavioral healthcare integration and the grant program that we've sponsored since 2009, that looks at integrating primary care within community behavioral healthcare settings. Since the program began in 2009, we have 94 grantees that are currently working across the country and helping more than 17,000 individuals get and stay well. Larry mentioned, with the Affordable Care Act, the potential for healthcare integration will grow exponentially, as 62 million Americans will access the mental health and substance use disorders for the very first times. Also, to note two other pieces of work in this area that SAMHSA has been involved in, and that's looking at issues of training for peer providers. Again, through our work in our BRSS TACS project, looking at developing core competencies that can be applied throughout peer provider training. And then more recently, in our fiscal year, president's proposed budget for fiscal year 2015, President Obama has expressly, specifically asked for $10 million for a new workforce training effort on peer professionals. This would be the largest investment in training of peers than ever before, and so I encourage everyone to keep track of that as that progresses forward. [00:14:54]

Clearly, the value of peers in all aspects of care is being recognized. Going forward, the future of specialty mental healthcare will change dramatically. We know that more and more services will be provide in integrated care settings. It's my great pleasure to welcome you all to this webinar. Again, thanks to Larry and the other presenters for really being lifesavers in the true sense of the word, helping develop and implement innovative and effective ways of helping people with mental health and addiction problems, save their lives and sustain meaningful lives in their community. Thank you again, Larry.

LARRY FRICKS: Thank you. We so appreciate your work and that's just great news about the $10 million in the budget for training peers. That's a wonderful commitment by SAMHSA, thank you so much. I want to now introduce Laura Pancake. Laura also has her masters in social work and over 20 years of experience in community mental health, primarily in the areas of employment and community integration, utilizing the psychosocial rehabilitation recovery models. Laura is the Corporate Director of Employment, Wellness and Recovery Services at

Pacific Clinics, coordinating the provision of wellness and recovery trainings, including the Health Navigator Skill Development Certification Training Program and the Employment Specialist Certification Course. She also serves as a liaison and provides support to research projects conducted by the University of Southern California, with Pacific Clinics, including the Peer Health Navigator Bridge Project. Recently, I had a chance to tour some of the remarkable work going on at Pacific Clinics and meet some of the navigators. Laura, thank you for this great innovation and thanks for joining us. [00:17:04]

LAURA PANCAKE: Thank you so much, Larry, and thank you Paolo for inviting Pacific Clinics and USC to participate in this webinar. We're very excited and very honored. Hello, everybody. Today, I'm going to talk about our Health Navigator Certification Training Program, or Project Bridge. The model was developed to train peers to teach consumers to effectively access and utilize healthcare, so that they can then go forward and self-manage their own healthcare. Within this model, a very interesting part is that peers were actually also involved in developing the intervention. They provide the training at this point and they continue to give feedback on the manual that we've developed to use in our training forms that we use daily, and so they have a big involvement in this.

The project began in 2008. We started with a three-year pilot research project that was funded by UniHealth, and IMH, and the Clinical and Translational Science Institute at USC. The lead investigator on this project was Dr. John Brekke, from the USC School of Social Work, and it was conducted onsite and in collaboration with Pacific Clinics. [00:18:18]

First, I'm going to talk about does health navigation work and what are the results of our pilot randomized controlled trial, and then I'll give you a little forward description of the actual intervention. We started off with a small sample, but we had very significant outcomes. We started with 24 mental health consumers from within our Pacific Clinics programs. The consumers receiving services from an intensive case management program. The treated group received health navigation for six months and the untreated group were wait listed for six month and then received health navigation after that.

We're starting now - I just want to take a minute and say that because the findings were so significant from this project, we're now undertaking a much larger study, of 150 consumers, funded by the Patient Centered Outcomes Research Institute, or PCORI, and it actually began about two weeks ago, so we'll have even stronger findings. [00:19:20]

Initially, some of the positive findings that we found in the study is that it was very acceptable to the consumers and tolerable to the consumers. Sometimes, and we still get this question, people are afraid the consumers are going to be hesitant to address their medical issues or fearful, and this is well founded because there's so much stigma and they've had bad experiences, but what we found is once they had become aware of their health issues and offered some support through health navigation, they were actually very, very excited and eager to begin to address their health problems. We also think this is because they began to see positive results very quickly. We also found that it was acceptable to agency staff at all levels, particularly nurses really benefited from this intervention and the assistance that it brought them in their role. Therapists, case managers, peers in other positions and even psychiatrists, were very welcoming of this once they became

familiar with what the intervention was and what a health navigator does. We also found that it was very feasible to integrate it into the clinics and the teams, and as I mentioned, in this pilot, we did it within and intensive case management team. Since then, we've rolled it out in outpatient clinics, wellness centers, and a variety of other programs. Lastly, we found positive findings, it was very feasible for peer providers to provide this service. [00:20:49]

Now, some people have expressed concern that they are - a peer provider said this might be too stressful and intervention for them to provide, it might impact their own recovery in a negative way, and we found actually, just the opposite. We did lots of interviews and focus groups, who have done them over the past few years, and we found that by serving in the role as a health navigator and providing the service, they actually feel that it really assists in their own recovery from mental illness, and they have started to take much more interest in their own physical healthcare and are taking care of themselves much more, and they also find it extremely rewarding. Some of these peers had served in other peer positions in the past and they found the health navigation even more rewarding than those. [00:21:49]

The next findings that we had were significant impacts on consumers health status. So, after six months, the total number of current health problems was reduced for people who were receiving health navigation. The treated group reported after six months, that they had an average of 5.9 medical problems. This is still high but as you'll see, compared to the untreated group, it was lower than the 9.3 health problems that the people who did not receive health navigation yet reported. And these health problems were not minor. There were things such as chest pain, dizziness, muscle and joint pain, nausea and pain in their abdomen. We also saw significant impact on health status in terms of significant reduction in overall bodily pain and the degree to which pain interfered with their daily lives. What we saw result from this is that if you can imagine, if you're in pain all the time, you're not going to be interacting with people, going out, socializing, and so as people's pain decreased, we saw them socializing more and they began to increase their support network which of course greatly improved their quality of life. [00:23:02]

The next impact on health status we saw were significant differences in physical medications that were prescribed. For the treated group, after six months of receiving health navigation, they were prescribed on average two medications and their symptoms improved. The untreated group, after the six months of no health navigation, were prescribed 4.7 physical health medications and unfortunately, their symptoms had worsened. We have some theories about this. One is that people continue to go and access healthcare ineffectively, through emergency rooms and urgent cares, seeing multiple doctors and being prescribed multiple medications, some of which they may have been taking and some of which they may not have, but were not receiving effective medical care. We also saw a strong relationship between the amount of bodily pain and the number of health problems, which wasn't necessarily surprising, and then we saw an impact on the number of psychiatric medications that people were prescribed. So the treated group, after receiving six months of peer health navigation, their psychiatric medications decreased by 0.25, but the untreated group's psychiatric medications increased by 1.5. Again, our thoughts on that is that as people's health becomes worse, their physical health, it's of course going to impact their mental health. [00:24:35]

Probably the most significant finding that we had or one of the most powerful, was a reduction in the choice of emergency rooms as a location selected by consumers for their usual medical care. Before people began health navigation, 33 percent of the sample chose the ER as the place that they would like to go and that they didn't like to do, but they chose to go to, to receive their primary healthcare. This could be, for some people, almost on a weekly basis, for others it would be only in a life threatening situation and receiving no other healthcare at any other location. We had 17 percent that chose to go to urgent cares and we had 44 percent that went to outpatient MD or primary care offices. After receiving health navigation, the number of people who chose the ER as their selected location for healthcare decreased to zero, as did the group that chose urgent care. The outpatient medical office visits went up and they chose those at 83 percent. And of course this is an increase that we want to see, because it's much more appropriate and effective healthcare. As you can imagine, this has significant implications in terms of cost saving. [00:25:55]

So just a summary of the findings. The health navigation intervention or Project Bridge, shows impact and promise for reducing health problems, all types of health problems, and reducing bodily pain related to health problems, which as I mentioned we saw have an impact on improving quality of life. Impacting the use of both physical medications, as well as psychiatric medications, and a big shift for the locus of healthcare from ERs and urgent cares to outpatient primary care.

Next, I'd like to just give you a little bit more of a description of what health navigation intervention is. It's a comprehensive healthcare engagement and self-management intervention. What does that mean? It's comprehensive in the sense that we connect consumers to mental health, primary care, substance use and specialty healthcare services, so we're serving the whole person. There's a focus on engagement, because many of the people that we worked with who have severe and persistent mental illness, were unable to successfully engage a consistent primary care provider or a healthcare home, and they gave up trying to access and use outpatient primary care. As you saw in the numbers before, many of them went to the ER instead. So a big focus on helping them find a doctor that can serve their needs, a doctor that they feel comfortable with and that they trust. Lastly, we focus on self-management. Our goal is to train and empower consumers to be assertive self-managers of their healthcare, so that their interactions with care providers can be more effective. [00:27:42]

So this model differs from other models that you've seen, in terms of care coordinators or case management or other types of health navigators, and the big difference is that we are teaching people the skills so that they can manage their own healthcare for themselves and access the healthcare system for themselves. We do this through a three stage model and our mantra is for them, with them, by them. So, through empowerment and self-managed care, we follow a modeling, coaching and fading model. So in the modeling phase, we're actually doing the skills for the consumer. We're making the appointment at the doctor for them, we're driving them to the doctor. We're sometimes even doing the primary amount of communication with the doctor because they don't feel comfortable yet, they don't have the skills yet. We're taking them to the pharmacy afterwards, we're taking them to the labs, and we're modeling those types of skills for them. [00:28:44]

The second phase is coaching. This is when we're doing it with them. We're sitting with them in the waiting room, which of course could be stressful for anybody because it's often a very long wait. We're helping them with their stress management, managing their anxiety. We're accompanying them into the exam room, but we're coaching them as they talk to the doctor and advocate for themselves. And then the last phase is the by them, and this is where we begin to fade out. The teaching of the skills fades out and they're doing it on their own, but they're checking in with us so that we can consistently offer them support, further coaching if they need it, booster sessions if they need it, and so that they can maintain and sustain the skills that they've learned.

The second critical element of health navigation is integration into the agency. You can send someone for training, they can be trained to be a health navigator, but if the team isn't ready to receive them, then it may or may not be successful. The team and the supervisors and management, everyone has to know what role the health navigator plays. There's some misunderstanding in the beginning, that a health navigator drives people to the doctor, and of course, as you can see and you'll see further in my presentation, that is definitely not what they do. [00:30:09]

There's three phases. The first phase is preparing the agency. We have an implementation and sustainability manual that we provide as part of our training, and where the team management, as well as the service team, talks about what role the health navigator will play, how this will fit in, what types of things in their agency may need to change to be able to implement health navigation. The second phase is actually training the health navigators on all the skills that they will need to then train and teach their consumers. But a really important part of the training is that we also train their direct supervisors on the competency that the health navigators will be learning, so that they can ensure that they're actually performing those competencies correctly, that they have the support, the health navigator has the support they need in working with their consumers in this challenging area. And then the last phase, following preparation and training, is integration, and that's when health navigation is integrated into the agency's practices and services. [00:31:20]

A critical piece of health navigation, in the model, is an assessment. I'm not going to go through all of the skills that are learned, but I wanted to touch upon this, because this kind of sets the stage for the whole health navigation process. It begins with an extensive and comprehensive assessment. Sometimes providers will say oh, I've already done an assessment on my person, I've known this person for ten years, I can't imagine there's anything else that I would need to know, let's just get to work. But then they report back that once they've completed the health navigation assessment, they've learned things that they would have never known about their consumer. So, some of the purposes of the assessment is to inform the consumer and yourself, so it's not just for you it's for them as well, of their medical status and their needs, their past experiences with medical care. Why haven't they been accessing medical care? With many people who haven't been to the doctor in over ten years, they experienced a lot of stigma and had some bad exchanges with healthcare providers, so we talk about that. And then we begin to identify strengths and barriers that they've had in accessing and utilizing medical services. It's used to increase the consumer's motivation to engage, and as I mentioned before, people are

sometimes concerned that because they haven't addressed, consumers haven't addressed their medical care in the past, that they'll continue to hesitate to do so and they'll be fearful. But once they've completed this assessment, they don't feel frightened or overwhelmed necessarily by their medical issues; they actually feel motivated to begin to work on them. [00:33:02]

Then, the assessment is also used to set the stage for goal setting. It's also very collaborative. It involves the health navigator, the mental health team, family members, significant others, whoever the consumer would choose to be involved, and it's also geared to increase motivation. Now, in health navigation, consumers set two types of goals. They set a health goal, which is focused on a specific health issue; controlling their diabetes, controlling their blood pressure, things of that type. But they also develop a wellness goal in terms of eating more nutritious foods, exercising, that type of thing, stress reduction.

The next slide that you have shows you the various consumer challenge points that consumers encounter when they're trying to access and utilize the healthcare system and have successful healthcare outcomes. The first row of boxes is all of the various stages, from the beginning to the end, that consumers might run up against some problems and things may start to break down. It starts with just becoming aware of what your health and wellness needs are, then looking at the environment. Do you need insurance, do you have a doctor, what types of resources do you need? The initial contact provider, provider contact, I'm sorry, in terms of calling the doctor and overcoming that fear. Getting to the appointment. We talked about the waiting room and exam room, sitting in those and then interacting with the doctor. We have many consumers who can make it through these stages, but where things break down is in the final stage of treatment planning and follow-up care. Going to the lab, following up once you get your lab results, going to the pharmacy and actually picking up that medication and taking it correctly. We offer a lot of skill building assistance there. [00:35:03]

The second row of boxes, and I won't go through them in detail but you can look at them later, are all of the different duties and roles the health navigator plays in each of these stages of accessing and utilizing healthcare. These also list some of the competencies that healthcare navigators will need to master as they're becoming certified as a health navigator.

There are three phases of health navigation as you're working with a consumer. The first phase is intensive, three months, of assessment, modeling and coaching, which I described earlier. This is when we're modeling the behaviors and the skills for consumers, and then coaching them so that they can learn to do it for themselves. The second three months is the fading and consumer self-management stage. This is when the consumer is calling to check in. How did my doctor's appointment go. I didn't understand what the doctor said, oh this is a question, I should ask for clarification, I'll follow up, and making sure again, that they can sustain those skills. And then phase three, which is somewhat unlimited, is ongoing support and boosters as needed. Let's say things are going well but then they encounter another health issue and they may need to go for specialty care. The health navigator would maybe become involved again, to offer them support and assistance as they meet with that specialty care provider. [00:36:32]

Health navigation typically lasts six months, but it's very individualized. We've had some consumers who only needed health navigation for two to three months, to deal with a specific

problem, and they already had many of the skills developed. We've had other consumers that health navigation lasted a year or more because they had a lot of issues, they had a lot of skills that they needed to build and develop, and so the health navigator will work with them for as long as they need.

A health navigator, just to give you an idea, as you're looking at your own agency and how it kind of works in real life. A full-time health navigator caseload is 12 to 15 consumers at any one time. Based on the length of the phases, they can serve about 30 to 40 consumers annually, with new admissions entering as clients begin to self-manage and with less support, and so consumers move out. So it's kind of a rotating and revolving caseload. And of course the part-time health navigator can handle about 15 consumers annually, and that's usually when they're working about 15 hours a week. In our structure, we also have a lead health navigator who supervises all of the other peer health navigators, and she is also a peer as well, and so she can lend her experience on many different levels as she's supervising the peer health navigators. [00:37:59]

And then I just wanted to add too, because this is a question that always comes up, is who's paying for this. We currently bill Medicaid, or in California it's called Medical, for this service, and that's fantastic in terms of sustainability. What we've done is we've taken the steps, with limited funding, to convert some of our current peer partner and case management positions into health navigator positions, because we have to address people's physical health first, before they can move forward in other areas of their life in terms of employment, education, and other goals that they may want to achieve.

If you'd like more information about our health navigation certification training program, you can visit our website. There's an H missing. It should be HTTP, but you can just go onto www.healthnavigation.org, and you can learn more about what the training involves, all of the different competencies that the health navigators learn, the structure of the training, information on implementation and sustainability, and then you can also look at some manuscripts in terms of the research that's been done. So, thank you very much. [00:39:15]

LARRY FRICKS: Laura, thank you, that was a wonderful presentation. We do have a few questions. First of all, because of stigma that you mentioned, how are navigators treated by primary care staff? What's the reactions working with people in recovery from mental illness?

LAURA PANCAKE: That's a great question, Larry. I'll be honest, we've had some mixed reaction. Our initial health navigator, the peer health navigator in the pilot study, did run into some pretty significant stigma from primary care doctors. But overall, what we found is that if they're being consistent and continuing to accompany and assist the consumer, the doctors are actually very relieved to have the health navigator in the room. And so what is often asked is does the physical healthcare provider ask you to leave the exam room if you're a health navigator, and they don't. We only go in the exam room of course, if the consumer wants us to, but when we're in there, the doctor is very happy to have extra support, very happy to help someone, help them communicate effectively with the consumers. And then we have some special forms, and ASME 3 forms and others, that the health navigator assists the consumer in preparing, so that the appointment goes very, very smoothly and the doctor knows that they're

taking those aftercare instructions with them and that they'll be followed up on. So overall, it's been very positive. [00:40:46]

LARRY FRICKS: Okay, and then we have several questions around the research. This may be something that we can follow up with, with John Brekke, because we'll follow up with all these questions. Are there validated tools used to track metrics for the health navigators?

LAURA PANCAKE: Yes, I believe so, yes.

LARRY FRICKS: Okay. That's something we can follow up with and get to John. What about in the pilot study, baseline measures of mental health, wellness compare with the first and second groups? Was there any sort of baseline measures looked at?

LAURA PANCAKE: Yes, there were baseline measures looked at and they did see an increase in the mental health of the consumers who participated in the study. I'm sorry, I don't have the specific name of those measures. [00:41:46]

LARRY FRICKS: All right, and we'll follow up on that one also. Any of the studies where some cultural aspects were taken into consideration? For example, African American with diabetes. And is the modeling portion of navigation cost prohibitive? Do you have any thoughts on that?

LAURA PANCAKE: Yes. I'll answer the last one first. The modeling portion is not cost prohibitive. We are able to bill that to Medicaid or Medical, to targeted case management, so it fits in very well to the current work that are staff are already doing, in terms of kind of traditional case management, in terms of modeling and doing it for them.

With the first question, in terms of cultural considerations. We did not look in this study specifically, at cultural issues. However, it was done with a group of people, primarily African American, in an urban setting in Downtown L.A., and since then, we've implemented health navigation in our Asian Pacific family center, with a population that is primarily Chinese, and we have two peer providers who are also Chinese, who provide that service. We've also implemented it with Latino, Hispanic population. And so what happens is the assessment allows you to begin to get into those cultural issues and preferences, and any other considerations that the person may have in terms of family involvement, their own beliefs, use of herbal and natural remedies, all of that can be accommodated within health navigation. We're very lucky, we live in a very, very diverse city of course, so we've had to adapt it to diverse populations, and we've had a lot of success with that. [00:43:39]

LARRY FRICKS: Laura, thank you very much. We'll now move on to our next two presenters, and we'll have some time also at the end for questions and feedback. NorthCare is one of a hundred behavioral health providers awarded PDHCI grants, utilizing peers as part of their program. The program, you see the slide here, the purpose is to establish projects for the provision of coordinating integrated services through the co-location of primary and specialty care services in community based mental and behavioral health setting. The goal of the PDHCI program is to improve the physical health status of adults with serious mental illnesses, who have

or are at risk for co-occurring primary care conditions and chronic diseases, served in community mental health settings. [00:44:41]

It's my pleasure to introduce Nancy Reed and Janette McKeever. Nancy is the director of the integrated care and wellness program for NorthCare in Oklahoma and has been with the agency for 26 years. She's certified as a psychiatric rehabilitation practitioner, with 37 years of experience supporting individuals in recovery. She has overseen the integrated primary health clinic since its inception in November of 2008 and is the project director for the primary and behavioral healthcare integration grant. Nancy is a strong advocate for recovery based services, working with peers, of the psychiatric rehabilitation program, to develop and implement a peer support volunteer league. All members of the volunteer league are working toward or have become a certified peer recovery support specialist. [00:45:41]

Janette is a peer recovery support specialist and case manager at NorthCare. She helped form the volunteer league at NorthCare. She is trained in QPR, as well as a certified advanced level rep facilitation through the Copeland Center, teaching rep at NorthCare. Janette is a member of the Oklahoma Recovery Alliance and serves on the Oklahoma Health and Wellness Commission. She helps mentor the new volunteers at NorthCare and is involved with the wellness initiative. Janette is a facilitator for a wellness group called Whole Health Action Management, WHAM, and also facilitates the smoking cessation group. Janette recently learned her CPRP, Certified Psychiatric Rehabilitation Practitioner, national certification. Thank you Nancy and Janette.

NANCY REED: Thank you Larry and hello to everyone. As we were getting ready to do this, I was talking with Larry about the roles that peer providers can take in an agency, and I was taken back 26 years. I've been supervising peer providers for the 26 years I've been at NorthCare, because my first charge was to change a very old fashioned, staff directed day treatment, into a psychiatric rehab program, and while I warned out executive director that I may be doing some things that people were a little uncomfortable with, when the first person I wanted to hire was one of the participants in the program, he kind of thought I'd lost my mind. It made perfectly good sense to me. Number one, we had really struggled with getting her to engage in the program, but once she did, she just took off. I mean she was in 100 percent, her leadership, her enthusiasm, her belief in recovery was just so apparent. She also met our current requirements for billing the service, so it was a no brainer for me, to bring her on as a staff member. And as we look at the slides, some of the slides were talking about the personal experience of whole health recovery, that includes addressing wellness of both body and mind. [00:48:02]

As we've had folks try to come into our program and give her the typical oh, I'm not sure, I don't know if I want to be associated with those people, and we've all, I'm sure heard that. Her response was always, "I am one of those people." Where I could talk about the philosophy of recovery, Jane lived it, day in and day out. She was able to model that for everyone coming into the program. Could not have been a better hire and probably was one of the reasons that program was incredibly successful. I've been doing peer support for a long, long time, and just find it to be one of the most useful things that I could do in terms of adding diversity to my treatment team.

The insight into the experience of internalized stigma and how to combat it. Again, starting back with psych rehab, I would find that helping folks learn to deal with the symptoms of schizophrenia was not near as difficult as dealing with the stigma and many times the institutionalization that occurred. That was a much more difficult challenge. I heard all too often, "Oh I could never go to work, I'm disabled," or, "My doctors told me I could never go back to school, it would be too stressful." And having on staff, people who had met both of those challenges, really helped dispel that myth and to help start removing that internalized stigma. [00:49:40]

Before I continue with this list, I'd like to punt over to Janette and have her tell you a little bit about her story, because it does really involve that internalized stigma.

JANETTE MCKEEVER: Hi, everyone, I'm glad you're all here. I was raised in a household with abuse and that has weighed on me for most of my life. I went into the military and had some issues there as well, and the biggest issue that was apparent to everybody is I had a weight issue. By the time I started working on my mental health issues, I was weighing almost 400 pounds, and this definitely impacted the amount of depression I was having, the mood swings I was having and all of those things. By the time I got to NorthCare, I was on 27 different medication, trying to combat the high blood pressure, the weight problem and all of the other things, and I was my illness. I told everybody here, I can't get better. Everybody tells me I'm going to be too stressed if I try to do anything and I just need to be a lump and stand in the corner and just wait for things to happen to me. Fortunately, when I got to NorthCare, people weren't going to allow me to do that. They were going to continue to remind me that I am worth saving, that I can do anything I choose to do, and I started to buy in. [00:51:12]

About three years into my work with my mental health, I had a severe medical issue. And this speaks to a lot of the stigma, because I went into the ER because I was in a significant amount of pain, and was dismissed by them saying, "It must be all in your head," because they read all the psych meds, and I know that this is a very common thing that happens to folks when they go into the ER. That pretty much knocked me all back down in my depression and everything, thinking okay, well maybe it is all in my head.

I finally got to an orthopedic surgeon who said, "This is not in your head, you need to have surgery." I had the surgery but couldn't come back to NorthCare, to my day treatment, because of all of the medications. It just wouldn't have been good for me to come back until I finished my physical therapy. And so my wakeup call that I had to work on both things was while I was gone, because while I was working on my physical health, I kind of let my mental health go off to the side, and then my pain increased and all the other things increased, and as I started keeping in contact with my case manager, who said, "Are you using your rep, are you using these things that we taught you?" I finally said, "No I'm not, but let me try it," and I got it out and by the time I finished my physical therapy and I got to come back, I was a different human being. I was on fire, I was ready to work on my own recovery, and I was ready to start other people because I finally got it. [00:52:56]

It isn't just about my mental health. It's my physical health, it's my support system, it is all parts of me that matter, and I went from having to take 27 different meds down to two, which is a

huge, significant difference. My blood pressure went to normal, I no longer had to take blood pressure medication. I had 15 suicide attempts at my worst, and I have not even had that on my radar for years, because I have worked on me as a whole person. I mean, I was dismissed by doctors because of my mental health, but now I am listened to because I know how to speak to my doctors, and that's a lot of what peers can do, is to help someone get ready to go to those doctors' appointments, with questions ready and an understanding of how they need to interact with that professional. [00:53:51]

NANCY REED: Thanks, Janette. When we start talking about the roles of peer supporters and the strengths they bring, I think it's pretty universal for any of us, when we face something that we're unaware of, unsure of, we want to talk to someone who's been there and done that. I know when I had an ACL blowout in my knee, it was great to hear from my doctor what the steps were. It was even better to talk to the guy in the waiting room that was one month post-surgery, that could really tell me what it's about. And I think that's one of the most powerful things that the peer supporters bring, and including how to really combat that internalized stigma.

As I've interviewed peer staff over the years, and peer volunteers, the one really, really consistent thing I hear is, "I want to give back in the way I was helped." I have found that the peer supporters can be some of the most patient, nonjudgmental individuals I've ever had the honor of working with, because they know a lot of people looked by some of their behaviors and believed in them. They also were able to really take away that, you don't know what it's like excuse. I have a peer support volunteer that works in our integrated health clinic who has lost 50 pounds. He is able now, to not take any blood pressure medication and he was on several, and he's also been able to go off his medication for diabetes. When we get folks coming in saying, oh well I can't lose weight, I'm on psychotropic medication, and then they speak with John and he's able to say, yeah it is hard but it is possible. So it kind of helps take away that, you don't know what it's like excuse. [00:55:42]

You can also really model that experience of moving from hopelessness to hope, and I think that's one of the role that peer providers do day in and day out, just with modeling, being here. Once I was in your shoes and now I'm a peer support specialist. I know Janette has another story that she'd like to share, about helping someone with the, you don't know what it's like excuse, and moving from that hopelessness to hope.

JANETTE MCKEEVER: I had someone come in not very long ago, to get help. She came in and said, "Well, nobody understands, you have no idea what it's like," and we talked about not just what brought her here, but also those positive, wonderful things that are going on in her life, and changed the focus from this crappy stuff is going on to, wow, I am a stronger person than I thought, and talking about things that she could do to change where she was and how we could really, really help her in getting on the right track, to getting to see the right people to get the things done that she needed to have done. [00:56:57]

A lot of the folks walking in the doors have multiple health issues but have given up, thrown up their hands, because either they say something like I did, when I went to the ER with my hip, or there's this wall of so much stuff to do that they can't - they just get overwhelmed by trying to get it all done. And so us, being able to talk to them about this is kind of what this would look

like and this is how this kind of goes, really helps them to say okay, I think I can do that, and that's really important.

NANCY REED: Our peer providers are also in a very unique position to develop a relationship of trust. Again, we use peer support specialists in our integrated health clinic to do the National Outcome Measures assessments, and what we have found is that out consumers coming into the clinic are much more honest with our peer support providers doing the NOM assessments than they are with any of the staff in the clinic, and that really leads us to being able to have that peer support provider talk with them about all of the different options they have in terms of other services. Whether it's going into some of our trauma services, whether it's taking RAP, whether it's taking WHAM, they really are in a position to have that very frank, very honest and very open conversation about how folks can take their life back and take charge of it. [00:58:30]

One of the things that I was asked to talk about, since I have been hiring and supervising peers for many, many years, the question is sometimes, how is it different supervising peers. Well it isn't. I think that oftentimes, when we start looking at hiring peers, we're looking at it with our clinician's hat and not with our supervisor's hat. I firmly believe you supervise peers the same as you supervise any other staff, and that in some ways it's almost disrespectful to think about doing it any differently. As with any staff member, I think it's really, really, really important that you have clear expectations, that they know what the job is and that their job description is very clear.

We have to provide adequate training and I think again, this goes to any level of staff. Really investing in your peer support providers with training and giving them the tools they need to be successful is so important. We do a lot of training upfront. All of our volunteers and staff go through a week long training with the Oklahoma Department of Mental and Substance Abuse Services, to become certified peer recovery support specialists, and then we provide ongoing training. [00:59:59]

The boundary issues that come up are different at times, for a peer support provider. They are sharing their personal stories. There can be some unique gray areas, that having that ongoing training and dialogue is incredibly important. We do a weekly group check-in with all of our peer support staff, whether they're a volunteer or paid staff, so that they have some of that peer support for themselves, and also use that as an ongoing time to hey, I got stuck here, how could I handle this differently. So it's an ongoing group check-in.

I think one of the other really important things is to educate the other staff on the team, as to the role of the peer provider. I talk about having someone on staff that's a champion. It was not without some difficulty, when we first introduced peer support providers, we did have a couple of staff going, "They're going to get the office up here with us?" It was like yes. So, some real issues with needing to let staff know that no, they're not trying to be therapists, no they're not trying to be case managers; here's what a peer support does. You know, they're there to offer hope, they're there to model, they're there to be a support system. We've been really fortunate, because our first group of peer support volunteers, most of which are now on staff full-time, like Janette, really took the role seriously and went out of their way to really earn the trust of the entire treatment team. So now when we have a new peer support specialist come onboard,

they're embraced. I can't train volunteers fast enough to fill all of the requests for assistance that I get from peer support. It's just been an incredible journey to watch just what they add to the team. [01:02:01]

The other thing I think they do for the team is they keep the team honest. It's a little hard to be sitting around the table during a clinical staffing and get bogged down in all the negatives about a consumer when you have a peer support specialist there reminding you to be focusing on the strengths, on what this person can do. I think they change the whole atmosphere at the clinical staffing table. So I'd encourage anyone out there to go for it, to hire peer support, to give them the training they need and to be sure and leave your clinician's hat on the table and put on your supervisor's hat as you're working with peer support staff. They deserve that respect and I've found it to be very useful.

JANETTE MCKEEVER: One of the thing I kind of wanted to say as a follow-up to this is, you know, those weekly check-ins, I may not see the other peer specialists all week, so me being able to sit down with all of them and kind of talk about our specific issues that we have during the week and supporting each other is really important. I know that I can pick up the phone and call any one of them and say, I'm stuck here, do you have some suggestions, and get plenty of suggestions, and we do support each other. But the other thing we do during this meeting is we set our own health and wellness goals. We hold each other accountable for the things that we want to change in our life, which means that we're taking care of ourselves, which is something that people who are in the helping field tend to not do. They tend to focus on everybody else and forget to take care of themselves, and that can be a huge downfall for anyone in the helping field. So this really helps us refocus on that. [01:03:50]

The other thing that's been really important for me is NorthCare has really cared enough about me and recognized how good I am at what I do, and have spent money to send me to trainings like RAP and WHAM, and the smoking cessation and all of those, so that I could bring those things back to NorthCare. It wasn't dependent on that oh, you're just this peer support. I was a staff member and I was good at what I was doing, so they sent me, and that's important. It shouldn't matter what your position is as far as being able to go and get training, and that's been just huge for me.

NANCY REED: I can't say it enough, that I believe that ongoing training is critical to success. I'm really anxious to talk more with Laura, because what she's doing with the navigators really ties into our PBHCI grant and how we're using peer support to offer RAP and to offer whole and to offer smoking cessation, and all of those different wellness, and to take it that step further and to help navigation, I think will be huge. So thank you very much, are there any questions?

LARRY FRICKS: Thank you both very much. The first question is directed at Janette. Janette, are you treated differently on treatment teams than others; have you been or are you? [01:05:19]

JANETTE MCKEEVER: I am not. In fact, I get a lot of questions asked of me as far as what does this look like, can you help somebody through this process. When I got in to staff and they absolutely listen to what I have to say and they listen to my concerns and then act accordingly.

I'm not dismissed like I thought that that might happen when I first started this. No, they take me very seriously.

LARRY FRICKS: We got a lot of questions about being able to bill for services, and we may have to have handle some of these in a follow-up. What about your situation there in Oklahoma? I know you've had a peer certification program for a number of years. [01:06:21]

NANCY REED: We're incredibly fortunate. Not only are we able to bill peer services to Medicaid, but also, our Department of Mental Health and Substance Abuse Services for our indigent consumers does reimburse us for not only peer services but wellness services. The focus has really expanded to include the wellness services, so our peer support providers are able to just provide such a wide variety of services and to be reimbursed so that it does keep it sustainable.

LARRY FRICKS: How do peers integrate their work with people in a sincere way within healthcare agencies? Do you see that that's being honored and respected?

JANETTE MCKEEVER: Absolutely, because I can give you for instance, I had a consumer recently who had a huge health scare, and so it was left to her, how she wanted to handle it. We kind of gave her some options and she kind of picked out what she wanted to do. I actually went with her, to help her in that process, and the feedback I got from her was that she felt like she was still in control but felt like it was helping her to not be so fearful of all the things that had to happen with her. And so she was still the driving force in what she needed to do for her own healthcare. She got to pick how she wanted to go down that road. [01:07:59]

NANCY REED: The other thing that I think is really critical is one of the roles our peer support specialists play, is talking with new consumers coming in the door and really letting them know the wide variety of services we offer, how they can get involved, what their responsibilities are, what are responsibilities are, so that we try to start a partnership with that consumer from the very minute they walk in our front door. Peer services is a big part of that process.

LARRY FRICKS: Janette, if you're a peer provider and a case manager, do you have separate caseloads?

JANETTE MCKEEVER: I don't. You know, when I see somebody, if it's case management, then I bill it as case management. If it's peer support, I bill peer support. I know the difference and the fact is, is most of the things I do is peer support. It is very rarely that I do peer case management. While I am certified to do that, my role is being a peer and I love being a peer and I would never give that up. I'm just very specific, when I'm working with somebody, if it's peer service, that's what I bill. [01:09:18]

LARRY FRICKS: We've got one other for Nancy. Is there a preference for hiring peers who have received services at NorthCare versus those who have not?

NANCY REED: That's something that I have struggled with for years and years. Once we formed the volunteer league and we kind of look at our volunteer as being a practicum and no

different than anyone that's getting a license and you go do a six month practicum. It's an opportunity for our consumers that want to go down this road, to try it on, to see if it's truly for them, and I have about a 50 percent dropout rate, whereas folks get going, they go man, this isn't what I thought, it's not for me. It gives us a chance to get folks trained, to watch their skill level. When I have a position come open, I've got someone that's already trained, already knows how to write clinical notes. We've seen their work, they're awesome. It's kind of a no brainer that that's who we're going to fill the positions with, are some of our volunteers. It does result in some interesting dilemmas in terms of services, and I've had that question asked a lot, do you let folks continue to receive services at NorthCare and be on staff. When folks are volunteers, and our volunteers do go through a lot of the exact same training our paid staff do, we do allow them to continue their services at NorthCare. They're not being paid, we are the indigent provider, the Medicaid provider, so we do allow folks to continue in services here. But we have a lot of conversations about boundaries, and that when they're wearing their volunteer tag, then they are not here for them, they're here to provide services for someone else. [01:11:05]

Once we offer someone a job and a paid position, then we do start working with them, of transitioning their services to outside of our agency. They're going to have our full insurance, so they have a lot more opportunities for choice of provider, and we want to keep those roles then, at that point, very clean. So, as someone comes onboard staff as a full-time provider, we do transfer services away from the agency. Hopefully that answers your question.

LARRY FRICKS: Thank you. There's questions about peer providers in specialty areas, such as HIV, being peer navigators, and for those different areas. And of course we're aware that in the area of addiction, that there's recovery coaches. I'm opening this up to all the presenters. Any thoughts on areas that this peer workforce could move into as healthcare reform fully integrates?

NANCY REED: Absolutely. We've had volunteers come from a variety of our different specialty programs, whether it's the health clinic and really being engaged and active because of the health clinic. We've had folks come to us through our trauma services. We offer a significant amount of trauma services and have had several graduates of that program and their main focus then is working with individuals in the trauma services component. We have some jail diversion programs where we've hired peer support specialists who have had that involvement with the legal system and have come through those programs to offer that hope that's specific to the participants in the programs, and I think that's just going to grow over time. I think it's an awesome way of really modeling for individuals, what is possible. [01:13:07]

LAURA PANCAKE: This is Laura. We're currently adopting health navigation to be used with families and caregivers of children. Of course it's a very different model. We're not teaching the child to health navigate for themselves, but we're teaching the parents and caregivers. And so that's been a huge area of need, an area of interest, and so we're currently adopting the model, writing the manual, and then we'll be piloting it within a Head Start program in the fall. We're doing it within Head Start because we found that health navigation can be used pretty much by anybody. I've often had times I think I needed a health navigator. So we're doing it in more of a general population so that it can be used for any family and caregiver.

LARRY FRICKS: Well, we've had several questions about the pay of peer providers. Any of you want to respond to that, sort of salary range or expectations of pay for those that are working as navigators or peer providers? [01:14:20]

NANCY REED: Go ahead, Laura.

LAURA PANCAKE: I was just going to say, and maybe it's what you were going to say, Nancy. I'm in Los Angeles and Nancy is in Oklahoma, so our salaries are going to be very different. I'll just say in general, and I have no problem giving numbers, our peer partners usually start out at about ten to twelve dollars an hour. The health navigators, because they have additional specialized training, their average wage is thirteen to fourteen dollars an hour, and of course the lead peer navigator is much higher than that. And then I believe there was a question maybe about can someone live on this, and so we have full-time health navigators, they're living on this, it's a livable wage, with the idea that they can then move up the career ladder from that position. I hope that answered the question. Go ahead, Nancy.

NANCY REED: I was going to say something similar, that a salary in Oklahoma is not comparable to a salary in California or New York or Denver, and so it's kind of hard to really talk about specific dollars. Part of it is going to be determined by - like Janette can do both peer support and case management. That allows her more billing options, and so her salary would be increased to that of a case manager, which is the higher level. We have peer support providers living on the salaries offered. I understand we're at the norm, we're a little higher for the state of Oklahoma, which is good, and of course there's always room for growth and opportunity to move within the agency. [01:15:59]

LARRY FRICKS: Here's a question for Janette. How does a peer support specialist connect with a new consumer? How does it happen? Where is the connection point? Can you give any examples?

JANETTE MCKEEVER: Every single consumer is met in the lobby, by one of our recovery support specialist volunteers. They're welcomed to NorthCare, we have hot coffee and stuff, we make sure they're comfortable, and then I, as a paid staff member, see probably oh, fifteen or so a week, of brand new folks, where I talk to them about services. I give them a little bit of my story to make them more comfortable, where they can talk to me about things that they really feel that they need to have in their services. And, you know, that's an awesome opportunity to talk about their whole health and wellness, and we actually have a wellness screening tool that we use when we do their screening as they're coming into the agency, where we ask them, do you have a primary care physician, do you have current medical health needs? And then talk to them about our healthcare provider here in our building. Did that answer your question? [01:17:23]

NANCY REED: I think there's also, Larry, a lot of warm handoffs. As I sit in the different clinical teams during the week, they'll have a consumer that maybe a therapist has been seeing for some time, that's going through a particularly difficult patch, that may need that additional support. And so they'll do a warm handoff to a peer support provider and bring them into that

team, so that they can add that extra support. Whether it's a phone call every day, whether it's an extra visit or two during the week, we do a lot of warm handoffs.

LARRY FRICKS: And then we've had a question about defining a peer provider, on asking people to disclose if they are peer providers. Janette, do you want to discuss that?

JANETTE MCKEEVER: Yeah, I do, because if you're going to be a peer support specialist, part of my job description as peer support specialist is that I will talk about my own recovery. Now, as a case manager, that's not something that I would do. However, because I wear both hats, I always go by what is appropriate for a peer support specialist. And so part of becoming a peer specialist in Oklahoma says that you will disclose. Now, that doesn't mean I have to tell everybody everything that's ever happened to me in my life at all, but what would be appropriate for them at that moment, yes I can disclose that. [01:19:00]

NANCY REED: We also utilize what the Department of Mental Health and Substance Abuse Services requires in terms of the certification to become a recovery support specialist. It starts with a high school diploma or a general equivalency diploma, GED, have demonstrated recovery from a mental illness, substance abuse disorder or both. And I'm reading these off the DMH website. Be at least 18 years of age, be willing to self-disclose about their own recovery, be employed or volunteer with a state behavioral health service provider or advocacy agency, possess good moral character, pass an examination based on the standards of DMH, and not be engaged in any practice or conduct which would be grounds for denying or revoking the certifications. So we use that as our requirements for peer support.

LARRY FRICKS: Okay, thank you very much. Laura, there was a question about - you may have mentioned this in your presentation, but there was a question about billing for navigators in your program there in California. We understand there's not actually a billing code or a billing service for peers, but you're able to bill for their services. Could you share a little bit about that?

LAURA PANCAKE: Sure. The peer health navigators are billing Medical or Medicaid using targeted case management and rehabilitation services. So, we're reimbursed at the same rate as a case manager, or other staff would be billing those services. And we've found that that covers just about all of the tasks that they have to do, so there's very little that's not billable. An example I can think of might be, which would be the same for any staff, is if you got stuck in a waiting room at an ER for twelve hours with a consumer, or something like that, where it would be difficult to justify billing for that whole time. And then we also are able to use, under the California Mental Health Services Act, it's called community outreach services, and some peer providers are able to use that service. It's a little bit more general and there's a little bit more leniency in terms of who can provide that and what's done under that role. It does not reimburse as that higher rate though, as targeted case management and rehab services. [01:21:37]

LARRY FRICKS: Okay, and I will mention that Georgia was the first state recently, approved for a Medicaid billing service called peer whole health and wellness service, and it's delivered by peers who have been through the WHAM training. We can get you information on that, because it is the first clearly designated service for peer whole health and wellness coaches delivering the

service of peer whole health and wellness, and it bills at a very robust rate. Okay, that is all we have time for in the way of questions. Hannah, were you going to take us through a wrap-up?

HANNAH MASON: Sure. I just want to thank you again, Larry, very much, for moderating today. As you'll see on the screen, some more information and resources. Feel free to visit our website at www.integration.samhsa.gov, or send an e-mail to integration at the national council.org. As I mentioned and I as I sent out to the audience, we will also be able to follow up with everyone's questions that did not get answered on the webinar today. I would also like to again, thank our presenters; Paolo, Laura, Nancy and Janette, for your time, and for sharing your valuable experiences. I also would like to thank everyone who was able to take the time to join us today for the webinar. Please don't forget to take the short survey that will go out after the webinar. Have a great day, thank you.

END TRANSCRIPT