Cost Effectiveness of Using Peers as Providers  
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The Center for Medicaid Services in its 2007 letter to states indicates that "Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State’s delivery of effective treatment." [http://www.cms.hhs.gov/SMDL/downloads/SMD081507A.pdf](http://www.cms.hhs.gov/SMDL/downloads/SMD081507A.pdf)

The Substance Abuse Mental Health Service Administration, a division of HHS, identifies peer support and consumer operated services as evidence based practices. The prestigious Institute of Medicine has emphasized the importance of peer support and peer delivered services in its landmark report *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. [http://www.iom.edu/Reports/2005/Improving-the-Quality-of-Health-Care-for-Mental-and-Substance-Use-Conditions-Quality-Chasm-Series.aspx](http://www.iom.edu/Reports/2005/Improving-the-Quality-of-Health-Care-for-Mental-and-Substance-Use-Conditions-Quality-Chasm-Series.aspx) The Annapolis Coalition on the Behavioral Healthcare Workforce has identified peer delivered services as one of its areas of emphasis to transform the behavioral health workforce and prepare for anticipated workforce shortages in the face of healthcare modernization. [http://www.annapoliscoalition.org/pages/](http://www.annapoliscoalition.org/pages/)

The major organizations identified above have all indicated peer delivered services work, but are they cost effective? The answer to this question as shown by the research done in this area might be best broken out into three domains as follows.

1. Using peer specialists instead of traditional day treatment
In 2006 the Georgia Department of Behavioral Health & Developmental Disabilities compared consumers using certified peer specialists as a part of their treatment verses consumers who received the normal services in day treatment (the control group). Consumers were randomly assigned to each group. Consumers using the services of certified peer specialists showed improvement as compared to the control group in each three outcomes over an average of 260 days between assessments in all three areas:
   • Reduction of current symptoms/behaviors
   • Increase in skills/abilities
   • Ability to access resources/ and meet their own needs
In comparing the costs of services, those using the certified peer specialists cost, the state on average per year $997 verses the average cost of $6491 in day treatment. That’s an average costs savings of $5494 per person for the state. (source: Fricks PowerPoint presentation at the SAMSHA National Mental Health Block Grant and Data Conference 2007)

2. Reduction of Hospitalization
Peer Bridgers are being used in a variety of setting throughout the country. One program run by NYAPRS was evaluated by Cheryl MacNeil, Ph.D. National Health Data Systems, who identified and examined several areas where the project benefited those involved:
"The most substantial finding is that the follow-up re-hospitalization rate of Matches while enrolled in the Peer Bridger Project was significantly less than the baseline hospitalization rate (i.e. the 2-year period prior to enrollment). That is, during the 2-year baseline period, the Matches were hospitalized an average of 60% of the time, while enrolled in the program, however, they were re-hospitalized only 19% of the time. That's an improvement of 41%!". (National Health Data Systems, December 1998)

More recent data analysis in 2008, the Peer Bridger Project worked with 229 individuals and 176 of those consented to the release of their hospitalization data. After initial review of this data, 125 of these individuals were not re-hospitalized in the state psychiatric center in 2009.
That means that **71% percent of the people the Peer Bridgers worked with were able to stay out of the hospital in 2009.**

http://www.nyaprs.org/peer-services/peer-bridger/
The OptumHealth Wisconsin Peer Bridger program targeted people in one geographic area who had at least two hospitalizations on average each year. In the past year since this population received Bridger services, **54% have not been re-hospitalized.** (source: internal OptumHealth analysis)

In another OptumHealth related example, certified peer specialists were used for the first time to offer respite services instead of immediately sending consumers in crisis to the hospital. Using this new service, Pierce County Washington was able to reduce involuntary hospitalizations by 32% leading to a savings of 1.99 million dollars in one year. (source: internal OptumHealth analysis)

In another OptumHealth example, certified peer specialist are being used as health coaches with late life populations. The average age of the consumer being served was 71. **100% of the consumers had been hospitalized prior to having a peer coach, only 3.4% were**
hospitalized after getting a coach. The Average length of stay prior to having a coach was 6 days. The average length of stay after getting a coach was just 2.3 days. (source: internal OptumHealth analysis)

Recovery Innovations in Arizona offers Peer Advocacy Services. This Hospital-based peer support is provided every day by Peer Support Specialists with people who are in the hospital; every unit at both Desert Vista and the MMC Annex. The Focus is on developing recovery plans and recovery-oriented discharge plans including strategies to reduce readmission.

Since the Peer Support Specialist staff have been working in the two hospital facilities, there has been, according to hospital administration, a reduction of 36% in the use of seclusion and a 48% reduction in the use of restraint, And a 56% reduction in hospital readmission rates. (Source http://www.recoveryinnovations.org/pdf/RIA%20Programs%20and%20Outcomes.pdf)

3. Increase in Adherence and other Positive Outcomes
There is a wide range of research that shows using trained peers leads to improvement in psychiatric symptoms and decreased hospitalization (Galanter, 1988; Kennedy, 1990; Kurtz, 1988). In studies of persons dually diagnosed with serious mental illness and substance abuse, peer led interventions were found to significantly reduce substance abuse, mental illness symptoms, and crisis (Magura, Laudet, Rosenblum, & Knight, 2002).

Consumers participating in peer programs had better adherence to medication regimens (Magura, S., Laudet, A., Mahmood, D., Rosenblum, A. & Knight, E.), had better healing outcomes, greater levels of empowerment, shorter hospital stays and less hospital admissions (which resulted in lower costs than control group). (Dumont, J. & Jones, K. 2002)

Dr. John Rush, primary researcher on the NIMH STAR*D depression study - the largest and most comprehensive study ever done in depression, did an evaluation of over 1,000 members participating in peer run programs through the Depression and Bipolar Support Alliance (DBSA), 95% of those surveyed described their participation as helping them better communicate with their doctor, 97% of those surveyed described their groups as helping with being motivated to follow instructions, and being willing to take medication and cope with side effects. Those who had been participating for more than a year were less likely to have been hospitalized in the same period (Lewis, 2001).
Those who participate in peer delivered services build larger social support networks (Carpinello, Knight, & Janis, 1991; Rappaport, Seidman, Paul, McFadden, Reischl, Roberts, Salem, Stein, & Zimmerman, 1985), and end up with enhanced self-esteem and social functioning (Markowtiz, DeMassi, Knight, & Solka, 1996; Kaufmann, Schulberg, & Schooler, 1994).

Peer delivered service participants showed greater levels of independence, empowerment & self-esteem. Over 60% indicated increased development of social supports.(Van Tosh, L. & del Vecchio, P. 2000). Involvement in peer support results in creation of a social network, change in role from helpee to helper, sharing of coping behaviors, presence of role model, and existence of a meaningful group structure. (Carpinello, S., Knight, E., & Janis, L. 1992)

**Conclusion**

Prestigious and important organizations such as CMS, SAMSHA, the Institute of Medicine among many others have identified peer delivered services offered through a certified peer specialists as being valuable services. In addition research is showing that while increasing consumer wellness, the use of peer specialists is decreasing costs.

**Selected References**


Corring, D. (2002). Quality of life: Perspectives of people with mental


support with dually diagnosed clients: Findings from a pilot study.
Research in Social Work Practice 8, 529-551.
Depressive and Depressive Association. American Journal of
Orthopsychiatry, 58.
context, and individual-group fit predictors of self-help group
attendance. In Powell, T. J.(Ed), Understanding the self-help
Publications, 88-114.
Magura, S., Laudet, A., Mahmood, D., Rosenblum, A. and Knight, E.
(2002). Adherence to medication regimens and participation in dual-
focus self-help groups. Psychiatric Services, 53(3), 310-316.
A Consumer-run support service. Psychosocial Rehabilitation Journal
12, 33-42.
Evaluation of operations and impact. Journal of Mental Health
Administration 20(1), 8-19.
Encouraging people with mood disorders to attend a self-help group.
participation. In Gartner, A. and Riessman, F. (Eds.) The Self-Help
Rappaport, J., Seidman, E., Paul, T. A., McFadden, L., Reischl, T.,
Collaborative research with a self-help organization. Social Policy 15,
12-24.
E. (1999). Giving and receiving help: Interpersonal transactions in
mutual-help meetings and psychosocial adjustment of members.
American Journal of Community Psychology, 27, 841-868.
Salzer, M.S., & Mental Health Association of Southeastern
Pennsylvania Best Practices Team (2002). Consumer-Delivered
Services as a Best Practice in Mental Health Care and the Development
of Practice Guidelines." Psychiatric Rehabilitation Skills, 6, 355-382.
service use of long-term members of self-help agencies for mental
health clients. Psychiatric Services 46(3), 269-274.
Trainor, J., Shepherd, M., Boydell, K., Leff, A. and Crawford, E.
(1997). Beyond the services paradigm: The impact of
consumer/survivor initiatives. Psychiatric Rehabilitation Journal 21(2),
132-140.