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Attitudes of Mental Health Peer-Run Organizations Towards Health Homes: Recommendations for Policy and Practice

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Abstract

This study examined peer-run organizations' attitudes towards collaborating in health homes. Data were drawn from the 2012 National Survey of Peer-Run Organizations. Multinomial logistic regression modeled the association between organizational willingness to participate in a health home and salient factors. Current efforts (OR = 5.05; p < 0.05), planned efforts (OR = 4.27; p < 0.05) to encourage physical healthcare, and staff size (OR = 1.09; p < 0.05) were associated with willingness to collaborate in health homes. Some organizations were concerned about power dynamics with potential medical collaborators. Relationships with medical providers, staffing capacity, and concerns about coercion should be considered when integrating peer-run organizations and health homes.

Keywords Peer support · Peer-run organizations · Integrated care · Health homes · Chronic care · Management

Introduction

Persons with mental illness have worse health status compared to the general population on a number of indicators, including smoking, exercise, obesity, and co-occurring physical health conditions (Dickerson et al. 2006) and also experience 25 years of life lost compared general population (Colton and Manderscheid 2006). To address these health disparities, health homes were proposed under the Affordable Care Act (ACA) as a financing mechanism for delivering care coordination, person-centered planning, and integrated mental, physical, and behavioral health services (CMS 2010). To best meet the needs of persons with mental illness, peer-run organizations are considered potential collaborators in these homes (CIHS 2012; Swarbrick et al. 2011). Peer-run mental health organizations are managed and staffed by people with lived experience of the mental health system (Ostrow and Leaf 2014) who have received formal training to deliver care to consumers of mental health services (SAMHSA-HRSA Center for Integrated Health Solutions 2016.) These organizations work in communities to provide non-medical community support to "members" who are people who participate in activities and supports as service users (Ostrow and Hayes 2015).

In recent years, peer supporters have taken a lead in delivering care focused on physical health and wellness, such as peer wellness coaching and illness self-management interventions (Swarbrick 2013). Peer support is a vehicle for building the skills and confidence of persons with serious mental illness (Institute of Medicine [IOM] 2012). Peer supporters have first-hand experience in managing their own health, and use this experience to assist others with similar conditions (Davidson and Guy 2012). These workers are increasingly employed in mental health systems to improve access to medical care as health navigators, wellness coaches, and to conduct outreach. Peer support interventions typically includes assistance in overcoming challenges related to diet, exercise, medication effects, and self-monitoring (IOM 2012). Studies have consistently found that peer support is effective for addressing chronic illnesses; especially interventions related to self-management (IOM 2012).

Because peer supporters staff peer-run organizations, these organizations could play a vital role in supporting their members in improving their physical health and wellness.

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Studies have shown that people with mental disorders are less likely to obtain the medical care that they need (Druss et al. 2011). This is partially due to perceived stigma from healthcare providers that inhibits access to care, but is less likely among persons who are more empowered (Ostrow et al. 2014). Peer-run organizations can increase empowerment among their members (Corrigan 2006; Rogers et. al. 2007), and may reduce self-stigma through related processes (Corrigan et al. 2009). In some cases, peer-run organizations have joined managed care networks, and can now support persons receiving services in health homes (Daniels et al. 2013).

Despite the promising nature of structured relationships between peer-run organizations and health homes, the attitudes of peer-run organizations towards this collaboration remain unclear. This is an important consideration given that previous studies have reported that peer-run organizations have concerns related to being involved in the delivery of mainstream health care services and Medicaid reimbursement (Ostrow et al. 2015). The present study examines (a) whether peer-run organizations are willing to participate as part of a health home, and (b) which organizational factors are associated with peer-run organizations' willingness to participate in health homes. Findings can help policy-makers and health system administrators anticipate challenges in including peer supporters in health home implementation.

Methods

Sampling and Data Collection

Data were drawn from first National Survey of Peer-Run Mental Health Programs to be published in over a decade—the 2012 National Survey of Peer-Run Organizations (NSPRO). To identify potential survey participants, the study team contacted statewide consumer networks (SCNs) and state offices of consumer affairs (OCAs) to obtain lists of peer-run organizations in each state. In states that did not have an SCN identified by SAMHSA or the National Coalition for Mental Health Recovery, local key informants were called upon to identify peer-run organizations. Peer-run organizations included in the Consumer Directed Services Directory of the National Mental Health Consumer/Survivor Self-Help Clearinghouse were also included. All organizations identified by the SCNs, OCAs, key informants, and national consumer-run organizations were contacted for participation in the survey. This sampling technique facilitated the identification and recruitment of peer-run organizations, which is important since these organizations can be difficult to reach. In total, 895 organizations/programs were identified through contacting statewide consumer networks and state offices of consumer affairs from August 2010 to June 2012,

and were recruited to participate in the NSPRO. Of these organizations, 715 responded, and 380 qualified for the study as "peer-run." Final inclusion criteria were related to management structure, which was operationalized by a consensus panel and have been addressed elsewhere by the study team (Ostrow et al. 2017). This consensus panel defined peer-run organizations as an incorporated, independent non-profit organization or a non-incorporated organization that operates independently from a non-peer-run parent organization; at least 51% of the board of directors or advisory board are people with a psychiatric history; the director is a person with a psychiatric history; and most staff members or volunteers have a psychiatric history (Ostrow and Leaf 2014). This is a common definition that has been used in previous research. Additional discussion of the study motivation and methods is presented in earlier papers (Ostrow and Leaf 2014). As is previous work, (Ostrow et al. 2015), organizations that did not provide direct services to their members (n = 20) or were already participating in a health home were excluded (n = 14). Finally, five organizations were excluded due to item nonresponse on the outcome variable. Following cleaning according to these criteria, 331 peer-run organizations were included in the present study.

The NSPRO is a web-based survey that contained 83 questions related to an organization's governance, staffing, activities, and perspectives on various policy topics, including the ACA. Not all respondents had to answer all questions because of skip patterns based on earlier responses. The survey was developed using two rounds of pilot-testing plus input of mental health services researchers, program directors, advocates, and government representatives. The survey was completed online by the directors of peer-run organizations from April–October 2012, and achieved an 80% response rate.

Outcome Variable

Directors were asked: "Would you be willing to work with other providers, such as doctors, to be part of a health home for your members? *A health home is a type of provider organization where multiple providers (such as primary care doctors, psychiatrists, and case managers) work together to coordinate health care*." Response categories included: "Yes," "Yes, but we have some concerns," "No," "Don't know," and "My organization/program is already part of a health home." We operationalized "health homes" in this manner to gain an understanding of how peer supporters feel about coordination with primary care, as opposed to coordination with mental health.

Independent Variables

Directors were asked about their knowledge of the ACA: "How much do you know about the Affordable Care Act (ACA)?" with possible response categories "Nothing," "A little," "Some things," "A lot," "Everything," and "Don't know." The question intentionally *did not* define the ACA; response categories were collapsed and "Don't know" was included with "Nothing/A little" because the question was not defined, and it was assumed that those who don't know how much they know about a policy are likely unaware of it and therefore more like those who said they knew "Nothing."

Respondents were also asked whether people within the organization had "discussed health care reform with a government agency or committee appointed by the government." The term "Health care reform" was used instead of "ACA" to identify discussions about policies that may be beyond the scope of the ACA, pre-date it, and to identify more general conversations about how the health system may be changing in ways that affect peer services.

Directors were also asked what plans they had to incorporate integration of behavioral and physical health into the organization's programs—including encouraging members to use physical healthcare services. They were asked about the frequency of *suggesting* members use a variety of different "non-peer-delivered" services, including physical healthcare. Respondents were asked to *not count* times that they or their staff had just given members informational materials. The possible response categories were: "never," "a few times per year," "a few times per month," "a few times per week," "daily," and "don't know." They were not asked to report actual counts because referrals—as may be counted by the medical system—would likely not be tracked in any reliable data source in a peer-run organization, and even if they were, would increase respondent burden, and potentially compromise response rate.

A peer-run organization's number of paid staff and the number of unduplicated members were also included as independent variables in this analysis. Number of staff members is a typical measure of organizational size (Jaskyte 2011). Members, as defined in the survey and in previous literature on peer-run organizations, are people who use the organization's services (Clay 2005). The number of members of the organization was controlled for in the analysis because the frequency of suggesting the use of services could be dependent on the opportunity to do so. The number of members was missing in 6% of reports. Because of missing data patterns in the analysis, the number of cases that would have been excluded was 13%. The number of members was imputed for missing observations using conditional mean imputation, with imputation conditional on the number of staff (Allison 2007).

Concerns About Participating in a Health Home

A follow up question about specific concerns related to participating in a health home was asked of those who said they were willing to be part of a health home but had concerns, those who said they were not willing, and those who said they were unsure. These individuals were then given a list of potential concerns that was created in advance of data collection. This list was created with the guidance of key informants, such as peer supporters, government officials, and insurance company representatives. The specific concerns were as follows: the providers will not understand recovery; losing control over the supports and services we can offer our members; afraid of doctors coercing members; conforming to medical model, having lower status than providers; and changing financing structures. Along with each potential concern, respondents were asked to respond: problem; not a problem; or don't know. Frequencies of these responses are reported.

Statistical Analyses

Descriptive analyses were conducted to characterize the study population. Chi square and analysis of variance (ANOVA) tests were conducted to evaluate differences within the study population, stratified by their willingness to participate in a health home. To test the associations of each independent variable on an organization's willingness to participate in a health home, multinomial logistic regression was used. Potential within-cluster correlation of responses by state in which participants were located was controlled for in the final statistical model using a robust variance estimate (Rogers 1993). All analyses were conducted in Stata 13 (StataCorp 2013). Because the questions asked key informants (i.e. peer supporters) to share their professional knowledge about topics related to their work, the Johns Hopkins Bloomberg School of Public Health Institutional Review Board deemed this study not human subjects research.

Results

Sample Characteristics

As shown in Table 1, a total of 331 peer-run organizations participated in the NSPRO and were included in the present study. Of these included organizations, about 40% (n = 131) reported they would be willing to be part of a health home; 32% (n = 106) reported they were willing, but had concerns; 14% (n = 45) were not willing to be part of a health home; 15% (n = 49) responded "don't know."

Approximately half (n = 168; 50.8%) of the organizations reported that they knew "nothing" or only "a little" about the

Table 1 Characteristics of peer-run organizations, stratified by willingness to participate in health homes

	Total (N = 331)		Yes (N = 131)		Yes, concerns (N = 106)		No (N = 45)		Don't know (N = 49)		χ^2	p
	N	%	N	%	N	%	N	%	N	%		
Knowledge of ACA												
Nothing/a little	168	50.8	59	45.0	48	45.3	27	60.0	34	69.4	11.33	<0.05
Some things	100	30.2	38	29.0	37	34.9	13	28.9	12	24.5	1.99	0.57
A lot	63	19.0	34	25.9	21	19.8	5	11.1	3	6.1	11.25	<0.05
Discussed healthcare reform with government agency	93	28.4	44	33.6	37	35.6	6	13.3	6	12.8	15.03	<0.01
Plan to encourage the use of primary care as part of integration	282	87.9	117	94.4	92	89.3	33	73.3	40	81.6	15.78	<0.01
Suggest physical healthcare to members												
Never	27	8.4	6	4.8	4	3.9	9	20.5	8	16.3	17.24	<0.01
Few times/year	56	17.4	19	15.1	17	16.5	11	25.0	9	18.4	2.33	0.51
Few times/month	92	28.6	39	30.9	32	31.1	10	22.7	11	22.5	2.3	0.51
Few times/week	79	24.5	33	26.2	33	32.0	4	9.1	9	18.4	9.99	<0.05
Daily	44	13.7	22	17.5	12	11.7	6	13.7	4	8.2	3.15	0.37
Don't know	24	7.5	7	5.6	5	4.9	4	9.1	8	16.3	7.4	0.60
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	F	p
Mean number of members[a]	1006.2	2968.8	1482.7	4688.9	758.4	1195.8	566.9	1556.2	910.7	1553.4	1.5	0.21
Median number of members	276											
Range number of members	0–33,125											
Mean number of paid staff[a]	12.0	38.95	17	57.3	12.5	34.7	3.7	4.6	8.2	9.9	1.4	0.25

[a]*M, SD, F*-statistic, and *p*-value derived from analysis of variance (ANOVA) test

ACA. Less than one-fifth (n = 63; 19%) of the overall sample reported knowing "a lot" about the ACA. Less than a third of the organizations (n = 93; 28.4%) reported that people from the organization had discussions about the impact of health care reform on peer services with a government body. Most organization directors reported that they had plans to encourage use of primary care services to incorporate integration of behavioral and physical health care (n = 282; 87.9%). Overall, only 8.4% (n = 27) of organizations reported that they "never" suggest to members that members use physical healthcare services. About a third of the sample (n = 92; 28.6%) reported suggesting that members use physical health services a few times per month. Across organizations, there was considerable variation in number of members served annually (mean = 1006, SD = 2968.8; median = 276; range = 0 to 33,125). The mean number of members did not differ across responses about health home participation. The mean number of paid staff was 12 (SD = 38.95).

There were some significant differences across outcome categories. Organizations that were willing to participate in a health home were most likely to report knowing "a lot" about the ACA (n = 34; 25.9%; $\chi^2 = 11.25$; p < 0.05). These organizations were also most likely to report having plans to encourage the use of primary care as part of integration (n = 117; 94.4%, $\chi^2 = 15.78$; p < 0.01). Organizations who were willing to participate in health homes, but with concerns were most likely to suggest health care to members "a few times a week" (n = 33; 32%; $\chi^2 = 9.99$; p < 0.05). Organizations who do not know if they are willing to participate in a health home had the highest proportion of respondents report knowing nothing or very little about the ACA (n = 34; 69.4%; $\chi^2 = 11.33$; p < 0.05). Organizations who were not willing to participate in a health home were most likely report that they "never" suggest physical health care to members (n = 9; 20.5%; $\chi^2 = 17.24$; p < 0.001).

Multinomial Logit Results

Table 2 details our multivariate results. The odds ratios (ORs) are relative to organizations that reported they were not willing to be part of a health home (n = 45; 13.6%). Organizations who were willing to participate in a health home were more likely to report having plans to encourage the use of physical healthcare services as an effort toward integration (OR = 4.27; p < 0.05), and to suggest that members use physical healthcare services a few times per week (OR = 5.05; p < 0.05). Being willing to participate in a health home with concerns was also associated with suggesting

Table 2 Multinomial logistic regression of predictors of willingness to participate in a health home

Predictor variable	Yes, willing to participate in health home[a]			Yes, willing to participate in a health home but have concerns			Don't know if willing		
	(N = 131)			(N = 106)			(N = 49)		
	OR	p	95% CI	OR	p	95% CI	OR	p	95% CI
Knowledge of the ACA									
Nothing/A little (reference)	–	–	–	–	–	–	–	–	–
Some things	0.86	0.72	0.39–1.90	1.15	0.79	0.41–3.22	0.64	0.41	0.23–1.82
A lot	1.24	0.78	0.27–5.73	1.24	0.76	0.32–4.86	0.44	0.50	0.04–4.72
Discussed HCR with a government agency or committee	3.04	0.08	0.89–10.38	2.91	0.10	0.81–10.49	1.38	0.70	0.27–7.04
Plan to encourage the use of primary care as part of integration	4.27	<0.05	1.31–13.91	1.87	0.33	0.52–6.70	2.14	0.17	0.73–6.27
Suggest physical healthcare to members									
Never (reference)	–	–	–	–	–	–	–	–	–
Few times/year	1.94	0.38	0.44–8.49	3.23	0.15	0.66–15.81	0.67	0.57	0.17–2.69
Few times/month	1.94	0.38	0.44–8.49	3.23	0.15	0.66–15.81	0.66	0.57	0.17–2.69
Few times/week	5.05	<0.05	1.16–21.89	11.20	<0.05	1.77–70.71	1.45	0.59	0.38–5.57
Daily	1.72	0.48	0.38–7.79	6.22	0.32	0.39–17.84	0.48	0.46	0.07–3.37
Don't know	2.27	0.30	0.49, 10.54	3.17	0.21	0.53–18.86	1.89	0.41	0.41–8.53
Number of members	1.00	0.57	0.99–1.00	1.00	0.72	0.99–1.00	1.00	0.80	0.99–1.00
Number of paid staff	1.09	<0.05	1.01–1.19	1.09	<0.05	1.01–1.19	1.09	0.07	0.99–1.18

[a]Reference category is "not willing to participate in health home", N = 45

that members use physical healthcare services a few times per week (OR = 11.20; p < 0.05). Organizational size was also related to willingness to participate in a health home. For every paid staff member, an organization was 9% more likely to say they were willing to be part of a health home or were willing but had concerns than to say that they were not willing (OR = 1.09; p < 0.05).

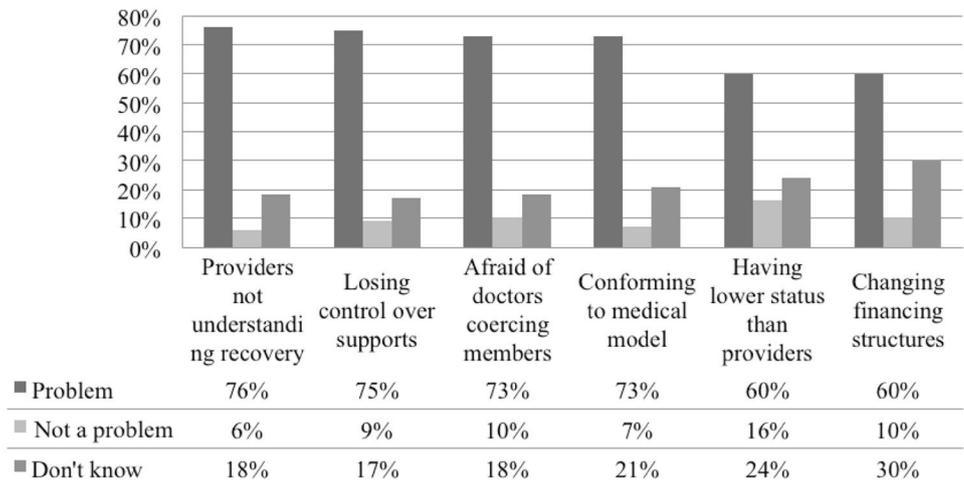## Concerns About Participating in a Health Home

Respondents who reported they were not willing to be part of a health home, were willing but had concerns, or didn't know if they would be willing were asked to report specific concerns about working with doctors and other providers in this type of arrangement. The most frequently reported concern was that "providers may not understand the recovery model" (76%) and "we are afraid we will lose control over the services and supports we can offer to our members" (75%). Other potential problems were that "we are afraid doctors will coerce or force our members into services, and our services are voluntary" (73%) and "working with doctors would force us to conform to a medical model" (73%). Less frequently reported concerns were "we will have lower status than other providers in the health home" (60%) and "we would have to change our financing structures" (60%). Respondents were also most frequently uncertain about the

latter (30% responding "don't know"). Figure 1 details concerns about participating in a health home.

Discussion

Results from this study suggest that a high proportion of peer-run organizations are willing to participate in health homes, but have concerns. From this study we can conclude four actionable implications that can promote the successful integration of peer-run organizations into a health home's multidisciplinary team. Some of these implications are promising and suggest that peer-run organizations can easily be implemented as collaborators in health homes, while others identify potential challenges peer-run organizations could encounter in this role.

First, several organizational factors were associated with attitudes towards participating in a health home. Peer-run organizations that have external relationships with medical providers and an existing practice of care coordination for physical health were more likely to have positive attitudes towards collaborating in a health home. Those who reported active plans to encourage healthcare seeking and those who already suggest to their members that they seek physical healthcare a few times per week were also more likely to report positive attitudes. This could indicate that

Fig. 1 Concerns about participation in health homes

	Providers not understanding recovery	Losing control over supports	Afraid of doctors coercing members	Conforming to medical model	Having lower status than providers	Changing financing structures
■ Problem	76%	75%	73%	73%	60%	60%
▪ Not a problem	6%	9%	10%	7%	16%	10%
■ Don't know	18%	17%	18%	21%	24%	30%

these organizations have existing relationships with health care organizations, which, in turn, could have "demystified" the act of collaborating with medical providers. Further, these organizations might have had previous positive experiences in delivering integrated care. Relatedly, organizational size was also associated with more positive attitudes toward working with medical providers in a health home. This may indicate the importance of organizational capacity when implementing innovations in service delivery (Jaskyte 2011; Jaskyte and Dressler 2005). Perhaps organizations with greater capacity are larger because they have a history of seeking out collaborations and funding opportunities with different types of service organizations. These larger organizations might continue to seek such opportunities to ensure the organization's longevity.

Further, our univariate results suggest that organizations that are more willing to participate in health homes have more knowledge about the ACA. Taken together, these results suggest that smaller organizations with fewer relationships with primary care providers and less knowledge about health care reform may resist partnering in a health home. However, smaller organizations might simply be unclear as to what "partnering" with a health home means, could lack the capacity to do so, or do not know how to initiate such discussions. Alternately, health care providers might be reluctant to reach out to, or could be unaware of smaller peer-run organizations agencies, even if the peer-run organizations were willing to collaborate. To overcome these challenges, peer-run organizations with previous positive experiences in collaborating with medical providers could serve as champions by encouraging and coaching smaller peer-run organizations in pursuing involvement in physical health care. A first step for champion organizations would be to help other organizations identify the right local medical provider and then share experiences in how to cultivate a care coordination relationship. Champion organizations could also share their knowledge about health care reform

with peer-run organizations with more limited knowledge on this topic.

Second, implementation studies of health homes have shown that many decisions are made at the local level through collaborations between government officials, agencies, providers, and other stakeholders (Takach 2011). While this variable was not significant in our multivariate results, our univariate results revealed that a higher proportion of organizations that are willing to participate in a health home were involved in discussions related to health care reform with local policy makers, and only a minority of participants in the present study (28%) reported participating in these kinds of discussion. These types of relationships between peer organizations and government agencies should be cultivated and nourished, while still allowing organizations that represent peers to claim and define recovery outcomes in the care setting (Hunt and Resnick 2015).

Third, participating organizations also reported several concerns that pertain to collaborating in a health home. These concerns generally reflected fears about behavioral and physical healthcare integration that have been previously documented in the literature (Croft and Parish 2013). More specifically, these concerns reflected the worry that their needs as organizations, and that of their members, will not be adequately addressed in an integrated healthcare system. Directors were concerned about the possibilities of unequal power dynamics between the peer providers and medical professionals, and of coercive treatment of their members. These concerns are related to the medical establishment's historical coercion and lack of understanding of recovery and should be anticipated and attended to by policy makers, educators, and health care administrators. Challenging power dynamics within the treatment system and advocating for recovery-oriented approaches has been a central goal of consumer/survivor initiatives (Ostrow and Adams 2012). Directors were also concerned about "losing control" of their organizations

and having "lower status" relative to other health care providers. These concerns are not unfounded. Despite efforts to certify, credential, and legitimize peer supporters, there is still confusion among traditional mental health service providers about peer supporter qualifications and roles (Davidson and Guy 2012). Lack of clarity among providers about the role of peers in health homes could present problems in implementing peer supports in these settings. However, some health care settings (e.g. the US Veterans Administration) have successfully integrated peers onto multidisciplinary teams. Ensuring that roles and responsibilities were clearly defined was seen as being an important component leading to success (Chinman et al. 2010). To overcome these concerns identified in the present study, one approach may be to have representatives from both the peer-run organization and the medical team familiarize themselves with each others' services, values, and approaches to care, perhaps in the form of a learning collaborative or another type of 'networking intervention.' The implementation science literature suggests that organizations with a greater number of external connections are more likely to be exposed to new ideas and therefore more quickly adopt new ways of service delivery (Palinkas et al. 2011). Planners of health home pilots and implementation should consider targeting peer-run organizations with existing relationships with primary care providers and patterns of encouraging members to attend to physical health and wellness. These organizations may be better suited to early implementation initiatives, and assist the system in learning strategies for engagement of other peer-run organizations in health homes in the future. Such interventions are necessary to improve their understanding of the perspective of peer-run organizations and peer supporters and facilitate acceptability and collaborative relationships (Siantz et al. 2016).

Our final point of discussion pertains to how some concerns might reflect the newness of the health home model. The possibility of changing financing structures was less frequently reported as a "big problem," but more frequently identified as "confusing" to respondents than any other concern. It may be unclear to peer-run organizations what is involved in financial arrangements in health homes. This may be because many of the organizations have not been involved with health homes, or discussions about health care reform more generally, nor have most of their members. The options for financing health homes include a monthly care management fee or network payments to connect to other behavioral and social services (Takach 2011). If peer-run organization directors receive skill-building education about the particulars of these mechanisms (which will vary by state), they may become more agreeable as the financing structures become clear.

Limitations and Strengths

These findings should be taken in light of some limitations. These data are cross-sectional, so causal inferences cannot be made. It should also be noted that these data were collected in 2012, prior to the executive order and other legislative steps that have aimed to limit the authority of the ACA. However, this study also has several strengths. First, this study utilized state-of-the-art survey techniques to reach a population that is difficult to study. The involvement of consumers and consumer researchers at all stages of this project was another study strength. Finally, the concerns reported in this study are from the peer-run organization perspective, which is essential for designing implementation and team-building approaches that address concerns about power dynamics between peer supporters and other providers (Fig. 1).

Conclusion

The mental health system and associated recovery movement have long perceived "exceptionalism" of the public health and primary care sector, because mental health services and policy have for so long been specialty sector serving people with serious mental disorders with different needs than the general population (Glied and Frank 2008). This began to change under the passage of the Mental Health Parity and Addiction Equity Act of 2008 (Glied and Frank 2008), and continues to wane with integration of physical and mental health services (Miranda et al. 2008). Peer-run organizations are generally willing to become a bridge for their members to improve access to health care services, care coordination, and other community-based supports, if the right organizational supports are in place for them and their potential health home collaborators in the community.

Compliance with Ethical Standards

Conflict of interest Both contributing authors have no relevant financial interests pertaining to this manuscript and certify that there are no conflicts of interest, including specific financial interests and relationships and affiliations relevant to the subject matter or materials discussed in the manuscript. The Johns Hopkins Bloomberg School of Public Health Institutional Review Board deemed this study not human subjects research.

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