Balancing Incentives Program

Interim Report for:

Using Peer Mentoring to Increase the Availability and Effectiveness of Consumer Directed Personal Assistance

Identifying Information:

Consumer Directed Personal Assistance Association of New York State

Contract Number: C029823

This document was developed under grant CFDA 93.778 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

The Consumer Directed Personal Assistance Association of New York State wants to acknowledge the work of Program Manager Brian Hollander, whose work on this report and throughout this grant has been critical, as well as our peer mentors, Athena Savides, Iffat Mahmoud-Khan and Sandra Lamb, whose professionalism and dedication is the basis of our success.

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Executive Summary

As part of the Consumer Directed Personal Assistance Association of New York State (CDPAANYS) continuing efforts to demonstrate the effectiveness of CDPA as one of the most effective ways of realizing the Triple Aim of improving quality and satisfaction, improving outcomes and minimizing costs, the organization has undertaken an effort to study the effectiveness of peer mentoring in helping consumers choose and succeed in CDPA.

CDPAANYS peer mentoring is premised on the several successful peer mentoring programs that have been instituted in a range of services, from independent living to alcoholics anonymous to mental health services and is available to consumers and Designated Representatives using CDPA. This valuable resource helps consumers and DR's to coordinate their long term care services and face the many challenges research has demonstrated CDPA poses to consumers, including the tasks of employment, the feeling of isolation and general confusion about the program. Whether someone is considering or just starting CDPA, or has been using CDPA for years, our experience shows they like the ability to improve their services and their quality of care by talking with others who use the program.

Halfway through the grant period, the project appears to be accomplishing these goals. Initial survey data shows that consumers who participate in peer mentoring state find the service very effective. Consumers first enrolling state that peer mentoring has helped influence their decision to choose to use the program by helping them learn about the general structure of CDPA as well as learn about some basic skills for building their programs. Consumers new to the program stated that peer mentoring helped to address questions and concerns such as recruiting, hiring, scheduling and effective supervision techniques. Consumers who have been long time users of CDPA stated that the service helped them to manage their programs more effectively, especially by helping them find solutions to challenges that are presented in the current changing health care environment.

While initial reports are encouraging, we have also seen the rapid damage to uptake that breaks in availability causes. Despite an active program in 2011 that raised awareness of the program for consumers in many areas throughout the state, any carryover was lost. Aggressive outreach was necessary to make plans, FIs and consumers aware of the program and increase the rate of people using the service, pointing to the need to identify new lines of funding so that it can be continued and grow. Additional partnerships could result in arrangements that could further strengthen the ability to increase outreach to consumers through active, instead of passive, outreach.

Interim Report on:

Using Peer Mentoring to Increase the Availability and Effectiveness of Consumer Directed Personal Assistance

Introduction

The Consumer Directed Personal Assistance Association of New York State (CDPAANYS) is the only statewide association with Consumer Directed Personal Assistance (CDPA) and the expansion and advancement of self-direction as its sole focus. The organization includes 21 member Fiscal Intermediaries (FIs) working throughout the state and representing approximately three-quarters of the people with disabilities and elderly who use the program.

As a Medicaid alternative to traditional home health care or visiting nurse programs, CDPA allows people with disabilities and seniors, who have stable medical conditions, to direct their own home health care and skilled nursing services. They recruit, hire, train, schedule, supervise and, when necessary, terminate their own workers, called personal assistants (PAs). A PA can be anyone who is not a spouse or parent. This means that in many cases, family caregivers can be paid for their services. In some instances, a person may be unwilling or unable to perform the responsibilities of a CDPA consumer. In these cases, consumers can designate someone to perform some or all of these tasks, known as a designated representative (DR).

As the State has moved forward with the continued redesign of the health care system, first through the Medicaid Redesign Team, and then through other initiatives such as the Delivery System Reform Incentive Payment (DSRIP) program, CDPAANYS has played an integral role in establishing CDPA as a benefit and ensuring that parties know how to effectively use it. Four years since the program's shift to managed care, CDPANNYS has successfully demonstrated to the majority of plans that CDPA is one of the most effective ways of realizing the triple aim of improving quality and satisfaction, improving outcomes, and minimizing costs.

… despite the numerous benefits that CDPA offers, its differences from traditional forms of service delivery create challenges for consumers that can limit its use or effectiveness.

However, despite the numerous benefits that CDPA offers, its differences from traditional forms of service delivery create challenges for consumers that can limit its use or effectiveness. Obstacles such as learning how to recruit PAs, becoming an effective supervisor, managing schedules, setting boundaries, and more routinely plague individuals as they use the program. Research has repeatedly demonstrated that these challenges and the consumer's feelings of isolation as they struggle through these issues lead them to either not consider using CDPA or drop out shortly after enrolling.

In 2011, CDPAANYS performed a pilot project providing peer mentoring services in CDPA. As a part of this 14-month grant, CDPAANYS trained eleven consumers as peer counselors. These individuals were trained using a curriculum focused on building their

capacity to understand CDPA, the concept of mentoring and person-centered planning. Peers in this pilot provided services to over 130 prospective or current consumers. The goal of the pilot was to provide peer mentoring services to consumers who were new to the program, as defined by enrollment in CDPA for 90 days or less. Of the consumers served, 81 were people who had been in the program for over 90 days.

While the pilot program demonstrated a desire for the peer mentoring service, it did not attempt to speak to the service's effectiveness. To address this, CDPAANYS applied for and received a grant through the Balancing Incentives Program (BIP) to provide peer mentoring services in CDPA. This grant assists CDPA consumers and DR's in addressing some of the previously mentioned challenges they face in building and managing a CDPA program. It also measures the program's effectiveness through evaluations from consumers, Fiscal Intermediaries (FI's) and Medicaid Managed Care plans (collectively, plans).

If successful, peer mentoring will:

1. increase participation in CDPA by **those not currently enrolled** by answering questions and addressing concerns;
2. increase the success rate of consumers just entering CDPA, **those in the program for less than 90 days,** by addressing problems with the program and helping the consumer create strategies to effectively deal with them; and
3. lower worker turnover, improve continuity of care and quality of care in **consumers using CDPA for over 90 days** by working with the consumer to identify strategies to help them successfully manage workers and their program.

> ***… a successful peer mentoring program in CDPA will not only benefit individuals seeking to use or currently using the service, it will help to redefine healthcare in the state and lower costs while improving services and increasing the independence and autonomy of seniors and people with disabilities who have chronic health needs.***

If successful, this project will demonstrate that the long-term implementation of a successful peer mentoring program in CDPA not only benefits individuals seeking to use or currently using the service; but, will help redefine healthcare in the state and lower costs while improving services and increasing the independence and autonomy of seniors and people with disabilities who have chronic health needs.

Background and Rationale

From the inception of the State's CDPA program in 1997 through November of 2011, use of the program grew slowly. In 2003, the program had 1,645 people[1]. Growing by approximately 500-750 people per year, it had 10,285 in 2010, right before it was moved to managed care[2]. Since the programs move to managed care (including managed long

[1] New York State Department of Health. "Interim Report: Home Health Care Reimbursement Workgroup." December, 2009. https://www.health.ny.gov/facilities/long_term_care/reimbursement/archive/hhc_workgroup/docs/hcrw_interim_report.pdf. Accessed on September 23, 2015.

[2] Department of Health. Presentation of Mark Kissinger to the MRT Managed Long Term Care Implementation and Waiver Redesign Work Group. "Long Term Care Waivers and State Plan Services." July 8, 2011.

term care), it is anticipated that the program has grown by over 50%, to roughly 15,000 individuals as of January 1, 2015[3].

This growth is likely the result of a number of different factors; however, they can all be distilled to the notion that CDPA has been repeatedly proven to facilitate the goal of the Triple Aim. Research undertaken since the program's creation in the mid-eighties as a pilot in New York City and several other states has demonstrated its ability to increase satisfaction over services delivered through more traditional home care models[4]. Studies also report significant reductions in unmet need, increases in patient safety and an improvement in outcomes[5,6].

Therefore, it is no surprise that the Department of Health indicated their support of CDPA early on as part of their effort to reform the health care system, requiring it as a benefit in mainstream managed care and managed long-term care on November 1, 2012[7]. Throughout this process, CDPAANYS worked with the Department of Health, managed care plans, and FIs to facilitate the transition.

When the State and the Center for Medicare and Medicaid Services (CMS) unveiled the Fully Integrated Dual Advantage (FIDA) program, once again CDPA and a plan's strategies for the service's use were highlighted[8]. In fact, the contract went so far as to say, "All Participants [must] have the opportunity to direct their own services through the Consumer Directed Personal Assistance Program (CDPAS).[9]"

While research exists demonstrating the success of CDPA in achieving the Triple Aim, and informs us of the barriers to getting individuals to use it, we do not have any indication as to how to bridge those barriers.

Through the education of plans about the many benefits CDPA offers, including lower costs and stronger outcomes, an environment was created that strongly encouraged use of CDPA in plans. One FIDA executive indicated that he felt the only way the plan could meet its savings targets required in FIDA would be through aggressive use of CDPA. In a presentation to another plan, a high-ranking official stated during the meeting to the

[3] Based on estimates using CDPAANYS members as a percent of the industry as a whole, assuming CDPAANYS members accounted for 75% of services.

[4] Benjamin, A.E., Ruth Matthias, and Todd M. Franke. "Comparing Consumer-directed ad Agency Models for Providing Supportive Services at Home." *Health Services Research*. 35(1), Part II. 351-66. April, 2000.

[5] Ibid.

[6] Robert Wood Johnson Foundation. "Choosing Independence: A summary of the cash and counseling model of self-directed personal assistance services." Spring, 2007.

[7] New York State Department of Health. "MRT Managed Care Benefit and Population Expansion." September 10, 2015. http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt1458_timeline.pdf. Accessed on September 23, 2015.

[8] "Three way contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in partnership with New York State Department of Health and <PLAN NAME>." July 3, 2014. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NewYorkContract.pdf. Accessed on September 23, 2015.

[9] Ibid.

care management staff that, “This program makes our members happier and saves us money. It’s a win-win. Find a way to use it.”

Research also reveals dominant themes on why people avoid, struggle with or drop out of CDPA. Studies have suggested that people are intimidated with the idea of needing to recruit or hire their own workers, manage timesheets, and take on the employer responsibilities[10]

While research exists demonstrating the success of CDPA in achieving the Triple Aim, and informs us of the barriers to getting individuals to use it, we do not have any indication as to how to bridge those barriers. The research has not discovered any peer reviewed studies about the effectiveness of peer mentoring in consumer directed or cash and counseling models, or even any attempts to implement such a program – outside the demonstration previously implemented on a small scale in New York. In cash and counseling programs implemented in other states, the counselors are usually not peers, and if they are, the emphasis is not on that fact.

However, peer mentoring has proven effective in achieving strong results in numerous service models. Most recently, the Fully-Integrated Dual Advantage (FIDA) program for dual eligibles required peer services to be made available[11]. It is one of the four required “core services” independent living centers must offer[12] and has effectively been implemented for veterans[13], trauma survivors[14], victims of domestic violence[15], those living with chronic health conditions[16] and those living with serious mental illness[17].

A previous pilot of peer mentoring in CDPA demonstrated a strong desire for the service among consumers. Original estimates were that the pilot would attract approximately 50 to 75 new consumers, defined as those not yet in the program or receiving CDPA for 90 days or less. Because of Hurricanes Irene and Lee, the period peers were operational was shortened from twelve months to eight. However, the peers still mentored 52 new consumers and, in an unanticipated development, 81 who were not new to the program.[18]

These results were achieved in a limited number of counties, since peers were volunteers and FIs did not consistently promote the availability of the services. The large majority of consumers were mentored by three peers, and of the 133 peer mentoring cases, 115, or

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[10] Brown, R., Foster, L, Shapiro, R. “Assessing the Appeal of Cash and Counseling Demonstration in Arkansas, Florida and New Jersey.” Mathematica Policy Research. July, 2005. http://aspe.hhs.gov/daltcp/reports/CCappeal.pdf. Accessed on May 3, 2014.

[11] NYS Department of Health. “New York State Department of Health’s Demonstration to Integrate Care for Dual Eligible Individuals.” Submitted to CMS on May 25, 2012. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYProposal.pdf. Accessed on May 3, 2014.

[12] New York State Education Law Article 23 – A, SERVICE CENTERS FOR INDEPENDENT LIVING - http://www.acces.nysed.gov/common/acces/files/vr/edlawarticle23a.pdf

[13] Stretch, R. H. (1985). "Posttraumatic stress disorder among U.S. Army Reserve Vietnam and Vietnam-era veterans." Journal of Consulting and Clinical Psychology, 53(6), 935-936. doi:10.1037/0022-006X.53.6.935

[14] Macauley, C. "Peer Support and Trauma Recovery," Journal of ERW and Mine Action, Issue 15.1, Spring 2011, pp. 14-17.

[15] Mitchell, R. E., and Hodson, C. A. (1983). "Coping with domestic violence: Social support and psychological health among battered women." Am. J. Commun. Psychiatry, 11: 629-654

[16] Michelle Heisler, "Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success", California Healthcare Foundation, December 2006

[17] Davidson. I., Chinman. M. J.. Kloos. B., Weingarten, R., Stayner. D. A., & Tebes. J. K. (1999). "Peer support among individuals with severe mental illness: A review of the evidence." Clinical Psychology: Science and Practice, 6(2), 165-187

[18] CDPAANYS. “Final Report for Contract #C-026453.” September, 2012.

86%, took place in 10 counties. Of these counties, all would fall into the categorization of rural except Westchester and Albany[19]. The lack of peers in New York City, Buffalo, Rochester or Syracuse, and no direct linkages with a FI in Long Island, led to muted participation, making the overall success even more pronounced[20].

As discovered in the pilot, many consumers have questions or concerns about their ability to direct their own program. Individuals who have enrolled in the program face numerous obstacles as they begin to implement their plan of care. The process of recruiting, hiring, training, supervising and terminating their own workers is overwhelming for many individuals not used to acting as a manager. Everything from basic corporate compliance and FI policies to the supervision and termination of workers raises potential issues[21].

Program Summary/Methodologies

CDPAANYS hired a program manager with significant experience in peer mentoring services. Three peer mentors (PMs) were hired and another was contributed "in kind" from an FI that provides peer mentoring services to its CDPA consumers. In order to qualify as PMs, individuals needed to be actively using consumer directed personal assistance. While discussion was had around whether or not designated representatives could serve as a PM, this ultimately was not a relevant question, as we received no applications from designated representatives.

The PMs were trained using a curriculum based on the adult as learner philosophy. Originally developed in conjunction with PHI and New York State as a part of the previous pilot project, the new curriculum contains numerous modifications based upon programmatic changes and delivery.

To avoid a situation where the traditional direction of a physician, nurse or agency merely is replaced by a PM, training focuses on listening and learning to ask open-ended questions that help lead the consumer to their own answers. In the process, the consumer builds the skills sets necessary to run successfully his or her own CDPA program. Peers then complete a form including demographic data on the consumer, the topic or topics discussed during the call, and other pertinent information.

On a regular basis, typically monthly, the PMs identify a common question or problem for a column on the website. This serves as a resource for consumers statewide where they do not have to engage directly with a peer or as a resource for PMs to use as they speak with consumers. It is also used to promote the service for other questions or problems through social media and other outlets. The peers have also created a "Frequently Asked Questions" document.

Between 30 and 90 days after using peer mentoring, consumers/DR's are contacted via e-mail, U.S. mail or telephone with an evaluation to measure the effectiveness of the program. Data from these evaluations is utilized to analyze the effectiveness of the service in relation to the program goals.

[19] Ibid.
[20] Ibid.
[21] Ibid.

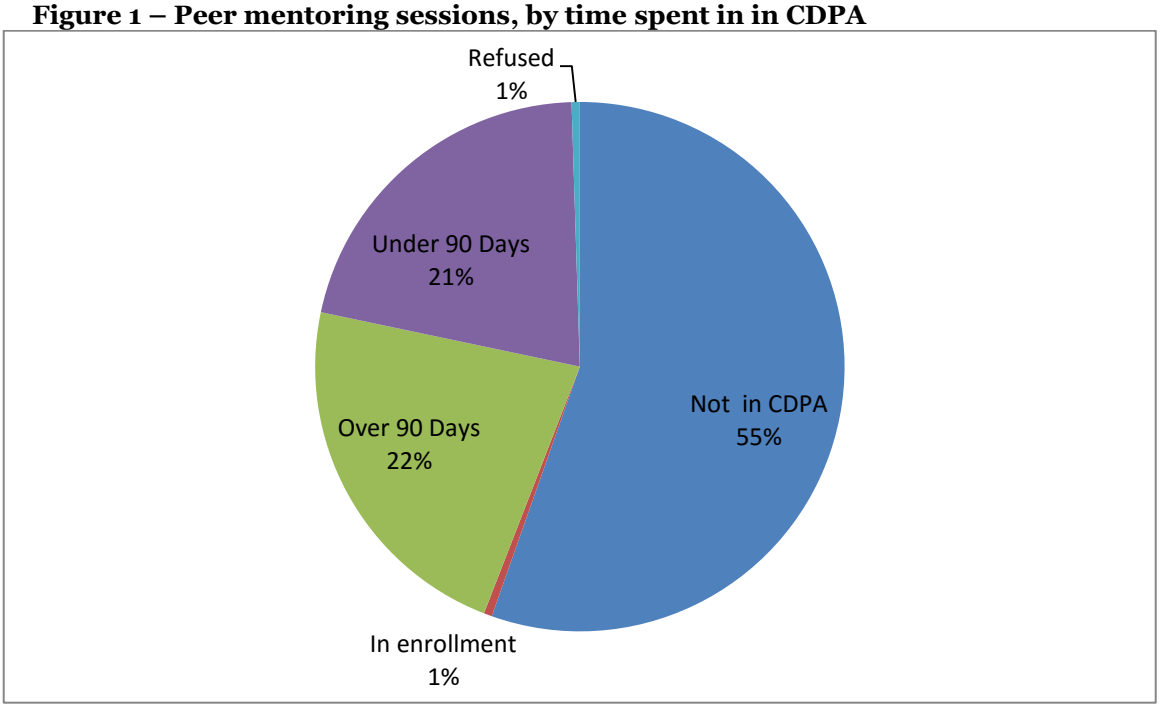
To create awareness of the availability and benefits of the peer mentoring service, informational brochures aimed at consumers, FI staffs and plan staffs were developed. These brochures were disseminated to FIs, plans, and other stakeholders known to CDPAANYS. These were followed up with telephone and face-to-face outreach regarding the program. The program has been continually promoted on the CDPAANYS web site and social media page and was featured in a workshop in our 2014 annual conference.

Findings

Halfway through the project, initial data indicates that *"Using Peer Mentoring to Increase the Availability and Effectiveness of Consumer Directed Personal Assistance"* is successfully demonstrating the effectiveness of peer mentoring in helping consumers build a strong CDPA program, including determining programmatic fit; recruiting, hiring and supervising staff; and through the provision of information about CDPA generally. Further, as knowledge of the program has expanded, indications are that it is being embraced by not only consumers and DRs; but by plans and FIs as well.

Over half of the consumers using peer mentoring have come to the program looking for more information about CDPA before they enroll. However, 43% of consumers using peer mentoring were enrolled in the program. Similar to the pilot program, this project does continue to demonstrate that individuals who are familiar with the program benefit from peer mentoring. One in five individuals who sought the services of a PM were in the program for less than 90 days. Almost one-quarter of those who used a PM were in the program for over 90 days.

Figure 1 – Peer mentoring sessions, by time spent in in CDPA



Consumers' varying amounts of time spent in the program, the myriad of potential issues that it presents to them and the complexity of the Medicaid system, particularly in light of the changes taking place as a result of the numerous recent reforms, results in a wide array of discussion topics between PMs and consumers, as reflected in Table 1.

Since just over half of the consumers were not yet in CDPA when they interacted with a PM, it is not surprising that approximately 500 of the callers were calling with more basic questions. These were generally related to the general structure of CDPA (285) or a discussion about whether or not the program was a good fit for them (222).

These topics were followed most closely by questions about day-to-day issues related to running an effective CDPA program. Hiring and recruitment (138), the development of effective supervisory techniques (33) and scheduling (25) were most common.

It was also clear that the many changes in the health care system, including changes to the Federal Fair Labor Standards Act (FLSA), are causing continued confusion for consumers. This was reflected in direct questions about FLSA (7), as well as some of the questions about Medicaid (9), managed care (31) and fiscal intermediaries (16). Many questions were from consumers using the program for a long time, seeking information about how to manage their programs in this changing health care environment.

Table 1 – Peer mentoring volume by topic

Topic	PM sessions discussed in
General CDPA Questions	285
Interested in Using CDPA	222
Hiring/Recruiting/Interviewing	138
Policies/Supervision	33
Questions About MC/Plans	31
Other	30
Coverage of Hours	25
Questions About FI	16
Medicaid Questions	9
PA Benefits/Wages	7
Federal Labor Standards Act	7
Non Medicaid Self Directed Care	5

To deal with emerging issues, PMs receive ongoing training about new topics as they arise. Topics are identified either by the Program Manager and Executive Director, or by peers as they begin to see an influx of new topics.

The variation in topics and the consumers varying levels of awareness of the program, and the questions to ask or how to answer the questions of the PM, inevitably results in significant differences in the amount of time PMs spend per call. While the average call length is 22 minutes, the longest call to date lasted almost three hours, while, in contrast, approximately 80 calls took five minutes or less.

This demonstrates the value of this service to FIs and plans who without the PMs would be forced to field these calls on their own, taking valuable time away from other services in a complex and changing health care world.

This demonstrates the value of this service to FIs and plans who without the PMs would be forced to field these calls on their own, taking valuable time away from other services in a complex and changing health care world, where resources are needed, and best dedicated, elsewhere. PMs are able to field the calls that would have taken significant resources from plans and/or FIs, and in many cases, because of the PMs experience using the program and the inherent credibility that provides, they are able to do so more effectively and in less time than it would take others.

It is worth noting that original project projections anticipated 2,500-2,750 calls over the course of the grant. With 434 peer mentoring calls as of this report, it is unlikely that we will reach that level. The initial projection assumed that progress would be built on the previous pilot program; however, what we found was that the time between the two programs eliminated any residual demand for such a program. Therefore, outreach had to be conducted and call volume did not start to increase for several months. While not related to the overall success of peer mentoring in helping people choose, stay in, or better manage their CDPA services, the initial lack of demand is worth noting and teaches significant lessons.

The value of the program is visible in both quantitative and qualitative data collected during evaluations. The overall response rate has been better than expected, with one

Two-thirds of those who use peer mentoring feel they are better able to use CDPA as a result of working with PMs.

out of every four individuals who receive PM services taking the time to complete a questionnaire.

In general, 85% of respondents stated that they would recommend peer mentoring to others using the service. This was true even for consumers who opted not to enroll in CDPA.

When asked for additional comments, multiple respondents made the same comment, stating, “This is a great program. The peer mentor was very helpful!

One-third of survey respondents using CDPA indicated that they would have not enrolled, or would have dropped out of the program entirely, if PM services had not been available. One respondent stated that the peer mentor was essential to helping her re-structure her entire program to put her PA’s on a more reliable schedule. She also stated that she might have had to drop out of the program if she had not received peer mentoring support.

Figure 2– Did Peer Mentoring help you choose to use CDPA?

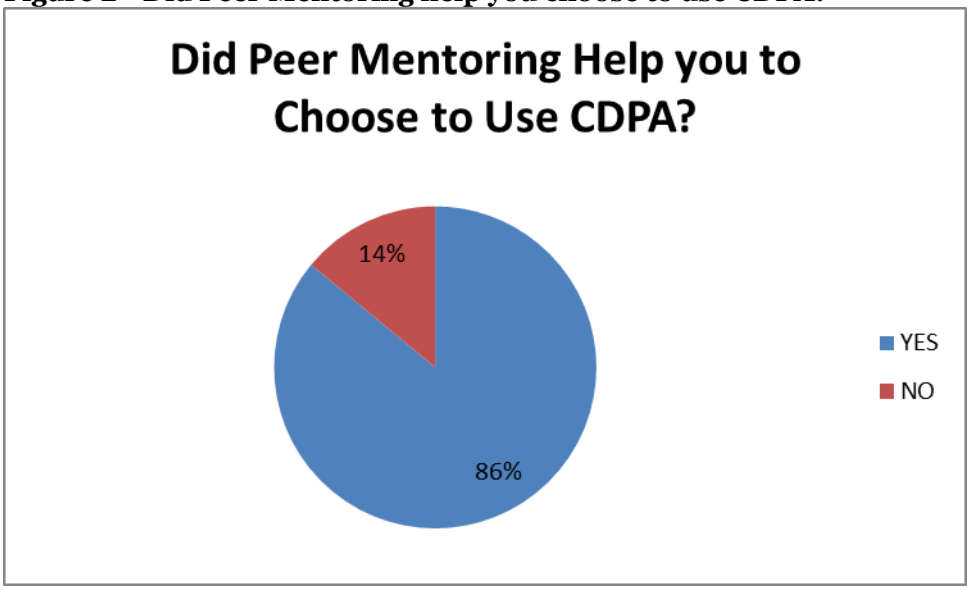
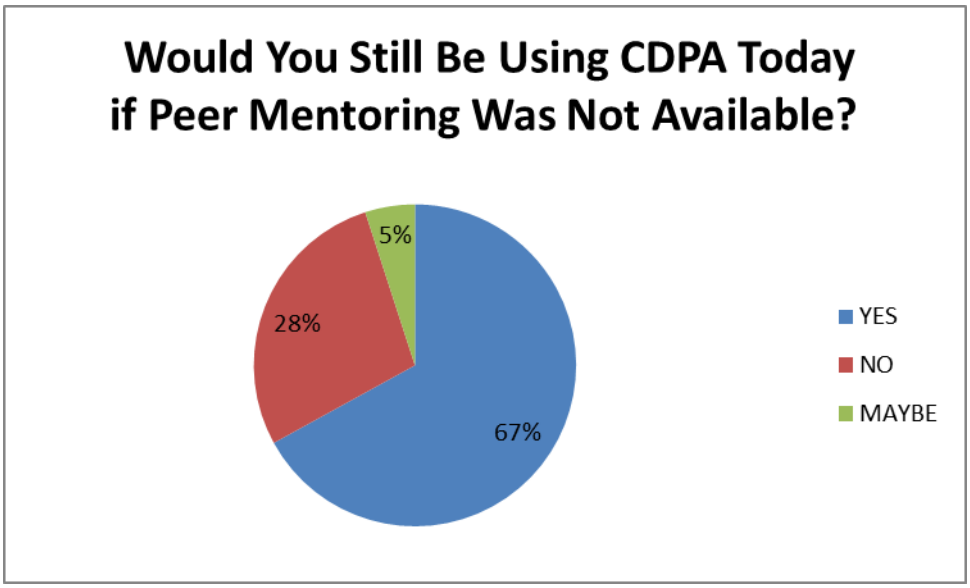


Figure 3 – Would you still be using CDPA today if Peer Mentoring was not available?

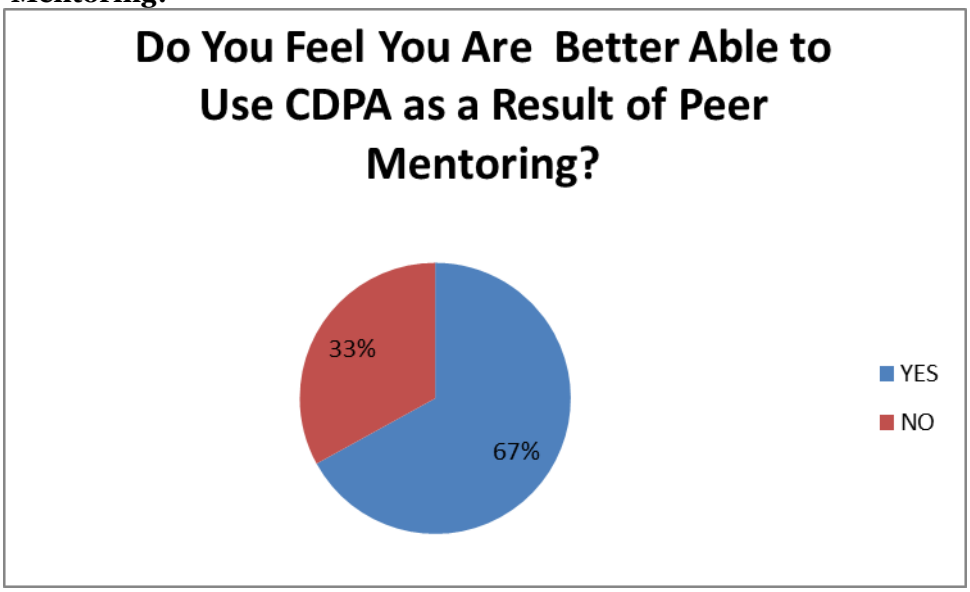


Two-thirds of those who use peer mentoring services feel they better able to use CDPA as a result of working with PMs.

A consumer who is currently using the program advised that she was having a great deal of difficulty managing CDPA before using peer mentoring. She stated "Peer mentoring is VERY HELPFUL' I use it regularly."

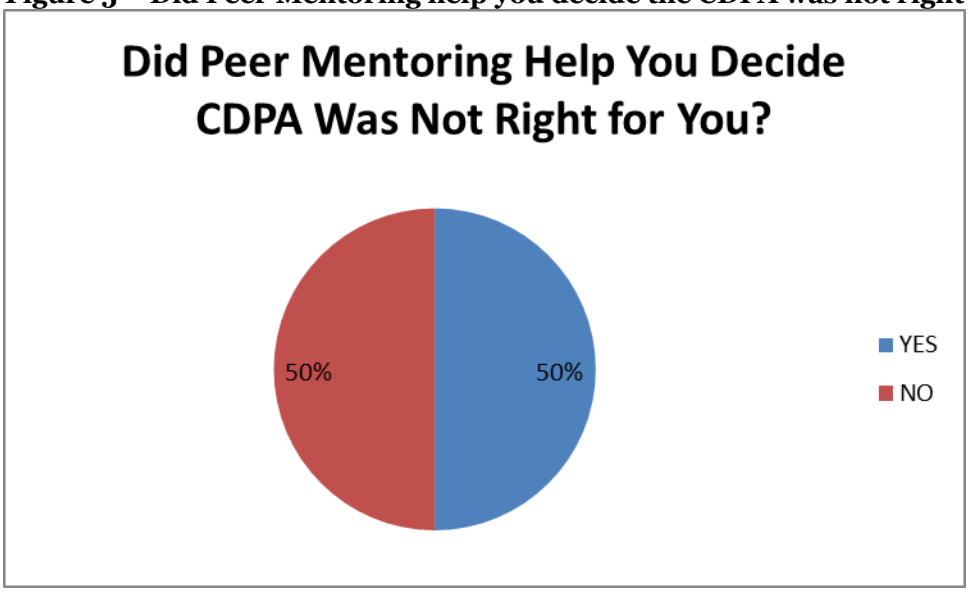
Another, who chose not to enroll in CDPA stated, "This is a great program. You need to advertise it more."

Figure 4 – Do you feel you are better able to use CDPA as a result of Peer Mentoring?



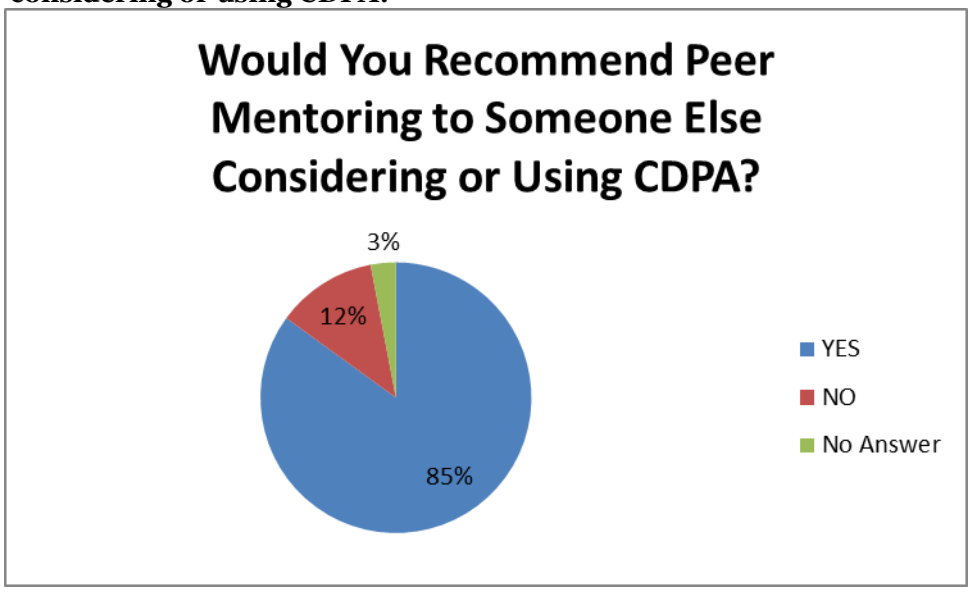
Equally important for success in the program is that CDPA is chosen only when it is the right choice. Ensuring that a consumer or DR fully understands, and is willing and able to fulfill the responsibilities that go along with CDPA, and is willing to accept them, is a key element for success. It is just as important to know when NOT to choose CDPA as it is to know when it is the right choice. One out of every two respondents who are not participating in CDPA stated that peer mentoring helped them determine that CDPA was not a good fit for them at this time.

Figure 5 – Did Peer Mentoring help you decide the CDPA was not right for you?



As stated above, fully 85% of respondents stated that they would recommend peer mentoring to someone who was using or considering using CDPA. This was also true for participants who did not choose to enroll in CDPA, or were no longer using CDPA. The DR for one consumer who passed away while the DR was participating in peer mentoring stated that the peer mentor was very supportive and helped her manage a very difficult time.

Figure 6 – Would you recommend Peer Mentoring to someone else considering or using CDPA?



Conclusions

When this project began, there were three primary goals:

1. increase participation in CDPA by **those not currently enrolled** by using peers to answer questions and address concerns;
2. increase the success rate of consumers just entering CDPA, **those in the program for less than 90 days** when engaging a peer mentor for the first time, by addressing problems with the program and helping the consumer create strategies to effectively deal with them; and
3. lower worker churn, improve continuity of care and quality of care in **consumers using CDPA for over 90 days** when they first engage a peer by working with the consumer to identify strategies to help them successfully manage workers and their program.

Based upon initial survey results, it is entirely reasonable to assume that all three project goals are so far being proven successful at this point in the grant.

As was shown, individuals who were not enrolled in CDPA prior to using CDPA indicated that being able to use peer mentoring helped them decide to use the services almost nine out of ten times, and in one-third of cases, the individual would have dropped out of CDPA entirely if not for the availability of peer mentoring. For a service that has demonstrated its ability to help achieve the Triple Aim, this alone is indicative

that peer mentoring within CDPA is useful, as it encourages people to use a program that increases outcomes and satisfaction while saving money.

Similarly, peer mentoring is a valuable resource in saving valuable resources for plans and FIs as they struggle to keep pace with the rapidly changing health care scene. The fact that over 430 calls took an average of 22 minutes each, with some taking over two hours, meant that plans and FIs were able to properly divert their resources while still answering their members and consumers questions, often improving the level of satisfaction that the individual had in their answers.

For those who were in the program, either for 90 days or less or for more than 90 days, two-thirds felt they were able to better manage their services as a result of using a peer mentor. Since we know that worker churn leads to higher costs for plans and FIs, and less continuity of care for consumers, the ability to strengthen a consumer's ability to manage successfully his or her program is one that all parties should constantly strive to meet.

But, it is also important to note that peer mentoring further advances the goals of the Triple Aim in how it handles those who are not appropriate for CDPA. Through active listening and engagement with an individual trained to ask the right questions, individuals investigating CDPA or experiencing problems with management of the program, are able to reach their own decision that the program might not be best for them. This saves the system enormous quantities of money, as individuals not appropriate for, or not committed to the responsibilities of, CDPA are much more likely to fail, requiring hospitalization, institutionalization and other much more expensive forms of care down the road.

Initial results point to the fact that while these services are critical and helpful, it is imperative to continue them. Consumers' knowledge of the program and/or willingness to use it decreases quickly with even a brief programmatic lapse. Additional partnerships could result in arrangements that could further strengthen the ability to increase outreach to consumers through active, instead of passive, outreach. Therefore, CDPAANYS will work hard to obtain permanent funding for this model and extend it beyond the BIP financing period.