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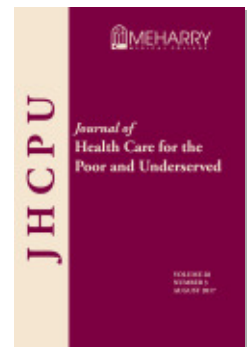
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# Universal Design for Underserved Populations: Person-Centered, Recovery-Oriented and Trauma Informed

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*Abstract:* Person-centered care has yet to be widely implemented in health care settings, a circumstance that disproportionately affects individuals with behavioral health disorders and those with trauma histories. A need exists for a universal approach to care that encompasses compassionate, collaborative relationships between providers and service users. Person-centered care, enhanced by recovery-oriented care and trauma-informed care, forms the basis for a universal approach to health care. For this paper, we adopted a modified Delphi method to establish consensus on a set of basic principles and practices for developing a universal design based on these three frameworks. We used a two-stage process to arrive at guidelines for use in health and human service settings by: 1) convening an expert panel to draft guidelines; and 2) conducting an online survey of multidisciplinary experts to refine the guidelines. We conclude with recommendations for implementation.

*Key words:* Person-centered care, trauma-informed care, recovery-oriented care, peer specialists, Delphi method.

“In the ER . . . again! For weeks my chest pain kept coming on strong. Just when it appears to subside, it gets going again. When I ask what is wrong with me, I usually get, ‘Wait, the doctor will come back to see you.’ Then the next thing I know, I am discharged and told the doctor has left or is too busy.

“The doctors seem to think my intentions are to overuse services and burden them. Their dismissive attitudes leave me feeling like an alien devoid of any ability to make human contact. When I express my need to be respected, it has only fueled the fire.

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There is never any pretense of caring for me in this hospital. All the appropriate words like 'patient-centered care' and 'individualized-treatment' waft like flimsy bubbles through the air. There is no substance, no actions, and no kindness to transform these words into reality."<sup>1</sup>[n.p.]

Universal design emerged in response to accessibility laws (Architectural Barriers Act, 1968; Section 504 of the Rehabilitation Act of 1973; the Fair Housing Act Amendments, 1988; and the Americans with Disabilities Act of 1990), which specified minimum accessibility requirements for products and built environments.<sup>2</sup> Architects and product designers working to meet these requirements developed a universal design to create and modify products and built environments to allow the fullest use possible among the greatest number of people.<sup>3,4</sup> Benefitting people with and without disabilities, the concept of universal design was expanded into education to create curricula and classroom environments that would reach the most children with the least amount of modification: an approach called universal design for learning (UDL).<sup>5</sup> The recent outcry for more responsive and compassionate health care<sup>6,7</sup> sets up an imperative for developing a universal design to address the needs of people with a wide range of health needs. The United States health care system is currently symptom-focused, fragmented, hierarchical, and primarily financially driven, resulting in access barriers, diminished quality of care, lack of continuity, and low service-user satisfaction.<sup>6</sup> In *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine (IOM) observed, "between the health care we have and the care we could have lies not just a gap but a chasm."<sup>6</sup>[p.1]

To bridge the quality chasm, the IOM recommended patient-centered care. In patient-centered, or person-centered care (PCC),\* continuous healing relationships become the centerpiece of widespread health care transformation to address the needs of people with chronic health conditions by fostering wellness. Providers and service users become partners in relationships that encompass the "qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient."<sup>6</sup>[p.48] These qualities are at the heart of PCC, "which is based on deep respect for patients as unique living beings, and the obligation to care for them on their own terms."<sup>8</sup>[p.100] Despite growing attention to PCC based on a "whole-person orientation" that integrates medical home principles,<sup>9</sup> this approach has not been widely implemented in hospital systems.<sup>10</sup>

All people interacting with health care systems are adversely affected by the lack of a universal design, but historically marginalized groups are disproportionately affected.<sup>11</sup> These groups include individuals with mental illness and substance use disorders (behavioral health disorders) and those with trauma histories, both of whom may suffer inordinately by the lack of PCC.<sup>12,13</sup> Mental health and substance use diagnoses affect 20% of adults annually and 50% of adults over their lifetimes.<sup>14</sup> Death among individuals with co-occurring mental and physical health disorders may occur 25 years earlier than their counterparts without these disorders.<sup>15</sup> In 60% of these cases, the cause of

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\*In this paper, we use patient-centered care and person-centered care interchangeably. Our purpose is to emphasize the overarching principles of both of these models.

death is treatable. Exposure to traumatic stress is also widespread and associated with poor health outcomes. Rates of exposure to traumatic stress are high in the general population and almost universal among low-income populations. More than one in four women and one in 10 men have experienced rape, physical violence, or stalking in their lifetime.<sup>16</sup> People with trauma histories face barriers to accessing care, find systems unresponsive, and often use services differently from the recommended use.<sup>17,18</sup>

Implementation of PCC is further complicated because many providers do not fully understand behavioral health disorders or the impact of trauma. For example, widespread biases are reinforced by health care providers' use of negative terminology to describe service users. This language influences providers' perceptions of people and the course of treatment.<sup>19</sup> This occurs against a backdrop in which more than half of all people experience behavioral health disorders<sup>14</sup> and nearly 90% report at least one traumatic experience in their lifetime,<sup>20</sup> which means that a majority of people accessing health care live with these conditions.

While person-centered care provides a promising foundation for appropriate care, it does not on its own fully respond to the health care needs of these subgroups or realize the potential for improving system-wide care. By integrating the principles of PCC with the principles of recovery-oriented care (ROC) and trauma-informed care (TIC),<sup>21,22</sup> we can develop a universal design that better meets the needs of all service users. Recovery-oriented care builds on the strengths of individuals, their families, and communities to improve health, wellness, and quality of life.<sup>23</sup> Trauma-informed care is grounded in an understanding of and responsiveness to the physical, psychological, and emotional impact of trauma.<sup>24</sup> Together the elements of PCC, ROC, and TIC provide a framework for carrying out the National Committee for Quality Assurance Patient-Centered Medical Home program's joint principles of integrating behavioral and medical health care,<sup>9</sup> and addressing the needs of these marginalized groups.

In this paper, we describe a process for developing practice guidelines for a universal design for health care using a Delphi methodology. We conclude the paper by discussing the practice, policy, and research implications of this approach.

**Background.** Expanding PCC to include the basic principles of ROC and TIC form the foundation of a universal design in health care. Below we review the critical components of these three frameworks.

*Person-centered care.* Person-centered care (PCC) was introduced decades ago to reduce the burden of disease and improve the quality of life for people suffering from acute and chronic illnesses. Central to its historical development was recognizing the importance of the relationship between providers and service users and considering individuals' experience within the context of their lives.<sup>25,26</sup> In *Crossing the Quality Chasm*, IOM recommended that health care be "safe, effective, patient centered, timely, efficient and equitable."<sup>6(p.6)</sup> The report listed 10 factors as the core of PCC: continuous healing relationships; customization based on the needs and values of service users; service users as the source of control; shared knowledge, evidence-based decision-making, safety, transparency, anticipation of needs, decrease in waste; and cooperation among clinicians. Publication of the IOM report sparked a surge in articles on PCC.<sup>27</sup> As summarized by Morgan and Yoder, the defining attributes of PCC are that it is holistic, individualized, respectful, and empowering.<sup>27</sup>

The ongoing, collaborative relationship between providers and service users is the cornerstone of PCC. The “patient” in a person-centered system is not a passive recipient of expertise, nor is the physician the sole authority on the individual’s illness narrative. Care is considered within the totality of an individual’s life, with attention paid to how treatment contributes to an integrated narrative that gives meaning to the experience of illness and its context. Once the individual’s needs and preferences are clarified, the provider and service user embark on a process of shared decision-making informed by scientific evidence.<sup>28</sup> In general, research suggests that person-centered approaches increase satisfaction with health care, health outcomes and quality of care, and generally reduce costs.<sup>29,30,31</sup>

*Recovery-oriented care.* Almost half of all adults experience a diagnosable mental health or substance use disorder in their lifetime,<sup>14</sup> but only 60% receive treatment—half in a medical setting, though only 13% of these settings are considered “minimally adequate.”<sup>32</sup> The addiction and mental health recovery movements emerged in response to the needs of people with these conditions. The mental health consumer-survivor movement—which includes hiring paid peer workers,<sup>33</sup> growth of psychiatric rehabilitation,<sup>21</sup> and greater understanding of the change process<sup>34</sup>—has been central in promoting the concept of recovery.<sup>23</sup> Recovery-oriented practice empowers people to make informed choices, shares decision-making with providers, sets goals that improve health outcomes, and encourages full participation in community life.

Differing definitions and principles of recovery have evolved over the years. The President’s New Freedom Commission on Mental Health defined recovery as “the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.”<sup>35</sup>[p.5] William Anthony, one of the pioneers of the mental health recovery movement, described recovery as a complex concept that encompasses recovery as a subjective experience, behavioral health outcome, and value system. Summarizing the underlying values and principles of recovery, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) highlights recovery as fostering stable health, home, purpose, and community. Recovery is based on respect; emerges from hope; is driven by self-determination and self-direction; involves a person through mind, body, spirit, and community; and respects cultural traditions.<sup>23</sup>

A major contribution of the mental health recovery movement has been its focus on peers. Peers model recovery as being possible and achievable, and provide hope by skillfully using their own lived experiences. Peers may work as part of multidisciplinary care teams, be in senior decision-making positions, or provide direct care. Peer specialists help the treatment team and service users shift the focus from deficits and illness to strengths, wellness, and recovery.<sup>36</sup> Despite a long history of organized peer support within addiction communities, only recently have peers’ essential role in services outside of mutual aid programs (e.g., Alcoholics Anonymous, Narcotics Anonymous, or SMART Recovery) been recognized.<sup>37,38</sup> Similarly, efforts to transform addiction treatment systems to be more recovery-oriented are recent and have generally received fewer resources than those in the mental health system.<sup>37,39</sup> Furthermore, people in recovery have provided services and led substance abuse agencies for many

years, but rather than being recognized as peers or people in recovery, they are considered professionals and administrators.<sup>40</sup>

Despite considerable progress, implementation of ROC in behavioral health and integrated care settings has not been fully realized due to lack of resources, workforce issues, inadequate training, fragmented care, stereotypes about behavioral health, limited adoption of evidence-based practices, and lack of peer inclusion in service implementation.<sup>11,41,42</sup>

*Trauma-informed care.* Trauma is pervasive among adults and children in the U.S.<sup>20,43,44,45,46</sup> Almost 90% of respondents in a national study reported at least one traumatic event in their lifetime, with multiple exposures being the norm.<sup>20</sup> Approximately 60% of children experience at least one trauma annually.<sup>45</sup> Within systems serving low-income populations (e.g., child welfare, homelessness), traumatic stress may be nearly universal.<sup>47,48</sup>

The TIC concept was introduced about 25 years ago, although the French neurologist Jean Martin Charcot and many others first explored the impact and consequences of traumatic experiences in the late 1800s.<sup>49</sup> Researchers demonstrated that the high rates of traumatic histories among those with behavioral health disorders necessitated a shift in service provision and an understanding of trauma dynamics.<sup>22</sup> They recommended that all providers at every level of an organization be provided training that focuses on the dynamics and long-term impact of trauma and that survivors' perspectives be included. Failure to do so may contribute to survivors' developing post-trauma symptoms (e.g., dissociation, anxiety), difficulty regulating feelings, problems with attention and concentration, disrupted relationships, interference with recovery, and reduced treatment receptivity.<sup>50,51</sup> When staff understand the dynamics and consequences of traumatic experiences, they are able to understand service-user behaviors as adaptive rather than pathological,<sup>52</sup> and are less likely to misinterpret their behaviors.

Trauma-informed organizations provide all services through the lens of trauma. Trauma-informed care has emerged as "a strengths-based approach grounded in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for providers and survivors and creates opportunities for survivors to rebuild a sense of control and empowerment."<sup>24</sup>[p.82] The principles of TIC include: understanding trauma and its impact; promoting safety; ensuring cultural competence, establishing trusting relationships; supporting service-user choice, control, and autonomy; sharing power and governance; integrating care; acknowledging that healing occurs in the context of respectful relationships; promoting recovery; and addressing secondary traumatization and promoting self-care.<sup>53</sup> As in ROC, people with lived experience are invited into organizational management and leadership.

Extensive research has demonstrated the link between trauma and physical and behavioral health problems.<sup>54,55,56,57</sup> Studies have also examined the effects of traumatic exposure on health care use. For example, women experiencing intimate partner violence are often reluctant to seek help specifically for violence, but use primary care and emergency services more frequently than others who are free from violence.<sup>17,58</sup> Subsequent research has demonstrated the necessity of developing systems that respond to the specific needs of individuals with trauma histories.<sup>59,60</sup> Advances in neuroscience have opened a window on the biology of trauma, providing explanations of what clini-

cians have observed for decades among trauma survivors.<sup>61</sup> Explaining the mind-body connection and describing how traumatic exposure during critical developmental periods changes brain architecture has expanded our understanding of how traumatic stress is manifested and how to respond.<sup>62</sup> Trauma research provided the impetus for founding the National Center for Trauma-Informed Care and the National Child Traumatic Stress Network.<sup>63</sup> The President's New Freedom Commission on Mental Health called for a research program under the National Institutes of Health to examine the consequences of trauma on the mental health of several at-risk populations including children, women, and victims of violent crimes.<sup>35</sup>

## Methods

To integrate the principles from PCC, ROC, and TIC into a universal design, we adopted a modified Delphi method to establish consensus among health and social service providers about basic principles and practices of a universal design. The Delphi method is an iterative method frequently used in health care and social services to transform individual opinions into group consensus.<sup>64</sup> Based on a multistage consensus process, often consisting of two to four rounds, it brings together recognized experts in the field from varied geographic areas to operationalize guidelines based on published literature and clinical experiences, and then revise them through expert judgment.<sup>65</sup> We used a two-stage process: convening an Expert Panel to develop practice guidelines and conducting a national online survey to refine the guidelines further.

**Stage One: Expert Panel review.** We convened a national Expert Panel to recommend practice guidelines for a universal design. To ensure that participants "begin with a common level of understanding and that the process is evidence-based,"<sup>66(p.36)</sup> we prepared a background paper that included a narrative review of the literature on each framework (summarized above in the Background section) and outlined the overlapping and unique aspects of the three frameworks.

In preparation for the Expert Panel, we conducted a brief online survey of Substance Abuse and Mental Health Service Administration's (SAMHSA's) Regional Administrators, who are part of SAMHSA's leadership team, to understand perspectives from the field. Regional Administrators were asked to rate the importance of the three frameworks and given the opportunity to provide narrative responses.

We chose 18 Expert Panel members using purposive sampling; this method relies on the expertise of researchers in selecting participants with knowledge about various elements of health care.<sup>67</sup> The first two authors (Bassuk and Latta) identified 10 key content areas and then identified multiple experts in each content area. Experts were identified through a review of the literature, our clinical and academic contacts, and suggestions from SAMHSA leadership. The 10 key content areas (with the number of panelists with knowledge in that area in parentheses) included: trauma (7), mental health (13), substance use (12), recovery-oriented systems (2), health care service delivery (11), people with lived experience of trauma and behavioral health disorders (4), health care administrators (6), health care providers (6), payers of health care costs (5), and policymakers (6). All panelists had knowledge expertise in more than one area; supplementary Table 1 presents the combined expertise of each panelist. In

addition to their subject matter expertise, panelists were chosen to ensure geographic, racial and ethnic, gender, and professional diversity. Fifty-six percent of the panel identified as male, 44% as female, 72% as White, 11% as African American, 6% as Asian American, and 6% as Latino/a. Sixty-seven percent were from urban locations, 11% were from suburban areas, and another 11% were from rural areas. Professional degrees of panelists included MD (22%), PhD or ScD (33%), Master's (11%), and Bachelor's (28%).

The two-day panel met for six hours each day with three breaks. The majority of panelists were present for the entire meeting, with two panelists able to attend 75% of the meeting. The virtual meeting was held using AdobeConnect web conferencing software,<sup>68</sup> which allowed for all panelists and facilitators to participate in plenary sessions and then break-off into smaller group sessions. Participants viewed the live video feed of presentations and fellow participants using video cameras and listened and participated through audio conferencing via telephone. Breakout sessions each used separate web conference rooms and dedicated audio conference lines. During plenary sessions, various panelists presented on selected topics including examples of integrated services and peer involvement based on the three frameworks. In small breakout groups, following each session, facilitators (first, second, and third authors) asked panelists to focus on the unique and overlapping elements of the three frameworks and how practices adopted from these frameworks might apply to hospitals and medical home settings. They were also asked to identify opportunities and barriers to implementing these approaches.

Results of each small group discussion were brought back to the larger group and discussed. They then generated draft principles and practices that might constitute a universal design. Using online polls in the virtual meeting room, panelists rank ordered the generated draft principles. From these discussions and the background paper, the Expert Panel developed a refined set of practice guidelines (see Results).

**Stage Two: National survey.** The practice guidelines were then distributed by email to a national group of 558 potential participants. Links to the survey were sent to existing lists of individuals who had participated in the Center for Social Innovation's Training Institute (t3) online learning or in related research studies. We included participants with experiences working in integrated health care and other medical and social service settings and implementing at least one of the three frameworks.

The survey was open from July 8, 2015 through July 26, 2015. Two emails were sent asking recipients to participate using the online program, SurveyMonkey.<sup>69</sup> Background information on the survey was included; participants were asked to provide demographic information including their profession and numbers of years working in the field. For each practice guideline, panelists were asked: "Please indicate your level of support for the following practice guidelines for a universal design in health care settings." They were given three choices: Do not support, weakly support, or strongly support. Participants were also encouraged to provide comments at the end of the survey. Consensus agreement on each statement was predefined as 80% or more endorsing "strongly support," which represents the upper end of agreement in the research literature on Delphi methods.<sup>65</sup>



## Results

**Stage One: Expert Panel.** First, our online survey of Substance Abuse and Mental Health Service Administration's (SAMHSA) Regional Administrators conducted as part of the Expert Panel preparation found overall consensus that "care must be first and foremost individualized and person-centered, delivered in a trauma-informed and sensitive manner, and the overall effort and outcome should be a journey of recovery or the self management of recovery or both together."<sup>\*\*</sup> Other findings from the Regional Administrators' survey included: 1) Behavioral health systems have made progress bringing these concepts to providers, 2) Hospital systems tend to be unaware of recovery-oriented frameworks, and 3) Implementation strategies lagged far behind.

The panelists developed guidelines arranged into two categories: 1) philosophy and vision, and 2) mapping to practice (see Box 1). These guidelines highlighted organizational philosophy, and systems and individual-level practices that would inform implementation.

**Stage Two: National survey.** We conducted a survey on the practice guidelines developed by the Expert Panel using a national sample of 526 medical, mental health, and social services professionals. The final response rate was 19%, with 102 participants completing the survey. The participants included those working in educational (6%), research (7%), hospitals (9%), outpatient mental health settings (14%), community health centers (20%), and other social service agencies (59%), such as substance use treatment, housing and domestic violence agencies, as well as members of the Expert Panel. Participants identified as medical health providers (6%), faculty or researchers (13%), case managers or outreach workers (24%), mental health providers (35%), and program managers or supervisors (42%). Fifty-eight percent of respondents had worked in human services for more than 10 years, and 80% of respondents worked in integrated health care settings. Most respondents had worked for more than five years with individuals with mental illness (80%), substance use (72%), and trauma histories (75%).

Of the 20 practice guidelines presented in the survey, 18 met criteria for consensus (>80% strongly agreed). Of these, 13 guidelines received more than 90% consensus, five received between 84% and 89%, and two fell below the a priori consensus rate of 80%. The practices that fell below the 80% consensus included:

- Revise all policies and procedures to incorporate principles of universal design (79%).
- Involve peers (people with lived experience) across the organization including leadership positions and in all activities, and ensure that positions are not subject to tokenism (75%).

## Discussion

Considerable progress has been made in achieving PCC, but a universal design that integrates what is known about providing care to individuals with behavioral health

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<sup>\*\*</sup>Quotation is a response to an unpublished survey.

**Box 1.**

**GUIDELINES FOR UNIVERSAL DESIGN IN HEALTHCARE SYSTEMS**

**1. Philosophy and Vision**

Core principles that underlie and infuse practice from a universal design perspective

1. Establish and disseminate a person-centered standard of care for service users
2. Place the person seeking services at the center of care
3. Acknowledge the importance of establishing a collaborative healing relationship between provider and service user
4. Establish foundational principles of care: safety, trustworthiness, choice, collaboration and shared decision making
5. Promote respect for all forms of diversity
6. Foster understanding of the impact of trauma, and mental health and substance use conditions
7. Promote the belief that recovery is possible and achievable for all individuals, regardless of vulnerability
8. Ensure that person-centered care is customized, transparent, documented, and based on a high level of accountability to the person seeking services

**2. Mapping to Practice**

System level

1. Form collaborative, interdisciplinary teams
2. Revise policies and procedures to incorporate universal design principles
3. Involve peers (people with lived experience) at all levels of the organization including leadership positions, and ensure that these positions are not subject to tokenism
4. Provide customized, ongoing training across all levels of the organization on the following:
  - a. The nature of mental health and substance use conditions and exposure to trauma, context of illness, social determinants of disease
  - b. Universal design principles and strategies for implementation that include trauma-informed care and recovery-oriented principles
  - c. Administrative and clinical leadership and staff, and relevant stakeholders are included in all trainings
  - d. Training should be ongoing, interactive, experiential, and based on adult learning principles
5. Integrate cultural traditions

Service level

1. Establish a mutually respectful, continuous relationship between service users and providers

*(Continued on p. 905)*

**Box 1. (continued)**

2. Expand assessment process to include the context of the service user's life, social determinants of presenting issues, and subjective experience of illness
3. Identify the needs, goals, and values of service users
4. Provider and service user participate in a process of shared decision making informed by scientific evidence
5. Providers negotiate service plans with service users and involve their families in health care decisions
6. Document the narrative and stated goals of service users in the electronic health record
7. Ensure that information systems and health records are transparent, available to service users, and are based on a high level of accountability to people seeking services

disorders and trauma histories can better address their needs. This study identifies practice guidelines that constitute a universal design for integrated care. The practices generated by this study meet the criteria for consensus among national experts in the field and are consistent with Patient-Centered Medical Home principles of providing “whole person” care within integrated health care.<sup>9</sup> Box 1 outlines the practice guidelines.

Two critical items in our survey were rated just below the 80% criteria for consensus: (1) revision of all policies and procedures to incorporate principles of universal design (rated at 79%); and (2) involvement of peers (people with lived experience) at all levels of the organization including leadership positions and in all activities, and ensuring these positions are not subject to tokenism (rated at 75%). Although very close to reaching consensus, some doubt existed among the survey respondents about the necessity of adopting a universal design and involving peer specialists in an organization.

The notion of a universal design is a bold and innovative approach that would require additional supports and strategies for implementation, as well as large-scale system change. Integrating these practices in the absence of a robust support infrastructure is a daunting endeavor that, in the current health care climate, is likely to provoke resistance. Learning another approach that requires training and clinical reorientation might be overwhelming to providers within the current regulatory climate, with the plethora of scientific and technological advances, and the challenges of Affordable Health Care. Providers may also resist adopting a universal design given the limited time they are able to spend with service users and their families. In our national survey, one participant responded: “If every hour of our day is booked (and double-booked), and the length of our appointments is shortened, we can no longer be as flexible or take the extra time service users have told us they value in their relationships with providers. There are also concerns regarding service users’ access to records, as providers may need to document information that should be delivered in person. . . .” This suggests that the next steps in moving a universal design forward will require both organizational and

provider buy-in and development of concrete guidelines that consider the realities of providers' work demands and environment.

Fewest survey respondents endorsed the involvement of peer specialists at all levels of an organization. Peer support services are a relatively new component of behavioral health care that emerged from the 12-step, self-help, and consumer-survivors movements<sup>70</sup> and many providers may be unfamiliar with their skills and potential contributions. Considerable discrimination toward people with behavioral health disorders exists. Additionally, widespread understanding of the value of having staff with lived experiences is lacking. Although emerging evidence about the value of peer involvement exists, such as reduced inpatient stays, improved relationships with providers, and decrease in behavioral health and medical costs<sup>71,72</sup>—peers' vital contributions to the current workforce are generally under-recognized, with many providers unclear about the various roles and responsibilities of peer support services.

Essential peer services include providing one-on-one support; facilitating groups; helping peers manage crises; teaching skills related to health, wellness, and recovery; assistance with the challenges of lifestyle changes (e.g., diet, exercise), medication adherence, and participating on collaborative teams and in leadership positions.<sup>73</sup> In the substance use recovery community, instrumental support includes activities that have been historically provided through case management, such as linkage to services and advocacy within diverse systems.<sup>39,74</sup> With proper training, peers may also serve as recovery coaches or offer supportive, non-clinical counseling individually or in groups. In addition, peers provide social support that can help reduce isolation and link service users to community resources.<sup>75</sup> In support of their roles, the Centers for Medicare and Medicaid Services (CMS) issued guidelines to states under the Patient Protection and Affordable Care Act for Medicaid billable reimbursement for community health workers.<sup>76</sup> The term community health workers include peer specialists, recovery coaches, and other peer staff with lived experience of behavioral health conditions. Currently, 42 states and the District of Columbia have adopted the 2007 CMS guidelines.<sup>75</sup>

While the Delphi method provides many advantages and is the preferred research method when little evidence exists on a topic,<sup>66</sup> various limitations should be borne in mind when considering the findings from this study. Purposive sampling, the most common sampling used in the Delphi Method, can be subject to researcher bias, as no objective standard of expertise exists and thus is dependent on the researcher's perspective when selecting participants. Additionally, reliance on these identified experts can limit the generalizability and scientific validation of the findings.<sup>77,78</sup> In addition, the majority of participants in the online survey worked in social service agencies, possibly limiting its generalizability beyond these settings. The sample for the national survey did not include anyone who identified as a peer or individual with lived experience. This may have affected the lack of consensus on the role of peer integration in universal design.

**Practice and policy implications.** Adopting a universal design requires systems change. Without concrete strategies that guide the development of a robust structure for implementation, health care systems are unlikely to move in this direction. Fortunately, roadmaps for system transformation already exist. For example, Best and his colleagues identified five rules that include: engaging individuals at all levels to lead change efforts;

engaging physicians; involving service users and families; establishing feedback loops; and attending to history, particularly previous systems-level change efforts.<sup>79</sup>

Organizational commitment is a critical early step. Leadership support is essential, but not sufficient to move systems change forward.<sup>80</sup> To ensure engagement, administrative leadership must commit sufficient time for staff to adopt a universal design. In addition, changing a system requires ongoing training in knowledge and skills that focuses on practice guidelines and strategies for developing an infrastructure to support these changes. Training alone is not sufficient and must be supported through learning communities and ongoing coaching and support. Finally, ongoing organizational assessment to determine progress and the need for mid-course corrections should also be implemented.<sup>80</sup>

**Research implications.** The need for a universal design must be justified by its ability to fulfill the Triple Aim of improving service-user experience, improving population health, and reducing costs.<sup>30</sup> While research exists on the relationship of ROC and PCC to increased satisfaction, health improvements, and reduced costs, more research is needed to establish the health and cost outcomes of adopting a universal design.<sup>81</sup> Pilot studies could determine the feasibility of implementation and track initial outcomes to support the promise of this approach.

**Conclusion.** A universal design for health care as envisioned by our study is built on the sustained, mutually respectful, healing relationship between providers and service users.<sup>26,28</sup> The healing relationship can only thrive when backed up by organizational infrastructure and supports (e.g., training, health information technology) that foster integrated care, team building, effective communication, shared decision-making, access to care, and ongoing quality improvement.<sup>29</sup> The practice guidelines outlined here offer a foundational step in transforming the U.S. health care system to provide better care while improving overall health and reducing costs.

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