Certification of Consumer, Youth, Family and Parent Peer Providers
A Summary of Regional Stakeholder Meeting Findings
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WWT is a collaborative project comprised of the California Network of Mental Health Clients, NAMI California, United Advocates for Children and Families, and the California Institute for Mental Health. Funded by the Mental Health Services Act and the California Department of Mental Health, the WWT Training and Technical Assistance Center supports the vision of the MHSA Act to transform systems to be client and family-driven. As such, WWT supports the sustained development of client, family member and parent/caregiver peer employment within every level of the public mental health workforce. www.workingwelltogether.org

This report was produced by Debra Brasher, MS, CPRP, and Lucinda Dei Rossi, MPAC, CPRP, of Inspired at Work. www.inspiredatwork.net consulting@inspiredatwork.net

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Introduction

Peer support is a long established and increasingly used practice that offers hope, inspires positive growth and promotes recovery and resiliency for individuals and their family members, parents and caregivers who are living with the challenges of a mental health issue. In California, the Mental Health Services Act (MHSA), passed by voters in 2004, stipulates that individuals receiving services for a mental health diagnosis, as well as their family members, must be actively involved in the development and provision of services to ensure system transformation toward a recovery and resiliency orientation. A significant strategy for system transformation is peer support. The MHSA has created increased demand and opportunities for individuals to receive and provide peer support services.

Nationally, most state mental health programs have opted to develop and fund peer support services through the federally funded Medi-Caid program. Most states have included peer support under the Rehabilitation Option within their state plans. Medi-Caid allows for a number of different ways to fund this service, including billing by service type and/or service provider, billing through stand-alone peer support organizations and billing under a capitated rate in a managed care system. States that bill Medi-Caid for identified peer support services have followed the recommended guidelines developed by the Centers for Medicare and Medicaid Services. These recommendations include the development of a certification program for peer support specialists as defined by the state.

Working Well Together, a collaborative of the California Network of Mental Health Clients (CNMHC), NAMI California, United Advocates for Children and Families and the California Institute for Mental Health, were tasked with developing a process to, “harness various stakeholder groups’ input for identifying certification standards for recommendations on a statewide basis”. To achieve this goal, Working Well Together conducted five regional stakeholder meetings across the State of California to gather feedback and input regarding statewide certification of Peer Support Specialists working in the mental health field. Inspired at Work, through a contract with Working Well Together, was engaged to conduct regional Peer Stakeholder Meetings during the months of March and April of 2012 in Redding (Superior/Northern California Region), Sacramento (Central Region), San Jose (Greater Bay Area Region), Los Angeles (Los Angeles Region) and San Diego (Southern California Region).

A total of 165 people attended these meetings. The survey that was used for data collection contained a list of fourteen categories of stakeholder/constituency groups. Each attendee chose to identify with one or more stakeholder groups. Consumer/Peer Providers were the largest category of attendees, followed by individuals representing Community-Based Organizations (CBO’s), and Family Member Peer Providers. County mental health administration representatives were also well represented.
While 42 percent of attendees selected only one group as their primary affiliation, a number of attendees selected more than one group/constituency. A number of individuals were wearing more than one hat as stakeholders.
The stakeholder meetings were organized so as to maximize input through a variety of strategies including:

- A research report provided prior to the meeting to familiarize constituents with key information about certification.
- A PowerPoint presentation covering the key areas of the report presented on the morning of the stakeholder meeting.
- Four formal opportunities to ask questions and provide feedback provided throughout the day of the stakeholder meeting.
- A written survey for stakeholder attendees that sought their opinions on a variety of issues regarding statewide certification.
- Focus groups to get stakeholder feedback regarding key issues effecting a statewide certification.
- Contact information of the meeting facilitators and inviting feedback following the meeting.

This report provides a summary of the input provided from the five stakeholder meetings as well as recommendations based upon the findings.

Focus Group Findings

Each focus group was asked to respond to four content questions relevant to statewide certification and one open-ended question designed to elicit feedback on information that may have not been covered in the various strategies to gather input. The five questions are as follows:

1. Which purpose for certification would you support and why?
   a. Formal validation alone.
   b. Formal validation and the ability to bill.
   c. Neither - I do not support certification.
2. Who do you think should be authorized to train peer providers and why? Please consider qualifications of the training organization.
   a. Should there be one training entity or more than one?
3. How should a training and certification process ensure that peer specialists are able to maintain their peerness?
4. In addition to standard supervisory excellence, what additional qualifications/training/experience do you think is needed for a supervisor of peer support staff?
5. Any additional comments/suggestions?
Purpose of Certification

1. Which purpose for certification would you support and why?
   a. Formal validation alone
   b. Formal validation and the ability to bill.
   c. Neither - I do not support certification

There were a total of 237 responses to this question. The responses were grouped into the three options listed above. Responses that did not reflect a direct answer to this question were categorized based on similarities. A total of 119 of the responses were directly responsive to the question. An additional 69 comments were about billing and certification. The remaining 49 responses could not be categorized as clearly responsive. Of the 119 responses, the vast majority were supportive of option b, “formal validation and the ability to bill” with a total of 87 responses. Twenty-six responses supported option a, “formal validation alone” and six responses supported option c, “not supportive of certification”.

Focus group respondents identified a number of positive reasons for pursuing certification of peer support specialists. These include:

- It legitimizes the role by establishing recognized standards of practice and a code of ethics.
- It may lead to professional advancement and salary increases.
- It may reduce some of the barriers to creating specific coded positions for peer support within civil service systems.
- It establishes a standard of practice.
It will provide peer support workers with a professional voice.
May help to reduce stigma and discrimination.
Will provide education to existing system of care employees on the role and value of peer support.
It allows for portability from one county to another.

While most people were supportive of certification and the ability to bill Medi-Cal, there were a number of responses that indicated a significant concern about billing. Nineteen responses were supportive of billing with caution and another 20 were simply concerns about billing. These concerns group into the following categories:

- Billing Medi-Cal will force peers into a “medical model” role that will require them to use language in a billable note that is deficit based and not person-centered.
- The ability to bill will lead to a requirement to bill with productivity standards that may erode the ability to provide important peer support that is not currently billable.
- Becoming part of the billable system may co-opt peers into system values at the expense of peer values.
- The current system of billing is onerous and takes a significant amount of time away from direct services.

Respondents expressed some hopes and opportunities that could result from certification that includes the ability to bill Medi-Cal, including:

- Awareness that a state plan amendment to include peer services could result in billing standards and language that are more supportive of recovery and resiliency oriented work throughout the system of care.
- An acknowledgment that in the Children’s System of Care, there is a barrier to providing services to family members in support of the minor receiving services. It is hoped that the inclusion of peer support could result in a billing code that is more expansive and directly tied to the provision of services to the family member or parent as a “peer”.
- An interest in the potential ability to create stand-alone peer operated centers that could bill for peer services.
- An opportunity to bill for “peer support” as well as the ability to bill to existing codes where appropriate both within a clinic system or a peer operated service.

**Training Peer Providers**

2. **Who do you think should be authorized to train peer providers and why?**
   
   Should there be one training entity or more than one?

Overwhelmingly, stakeholders believe that Peer Support Specialists should be trained by other peers or qualified persons with lived experience. Sixty-four percent of the responses reflect the opinion that only peers should train peers. An interesting caveat to this is that while a few people
thought that any peer (TAY, consumer/survivor/parent/family member) could train any other group of peers, the majority of responses reflect the opinion that specific peer trainers should train to their direct lived experience. For example, Parent Peers should train Parent Peers and so on.

Another 29% of the responses expressed the opinion that a team of trainers would be appropriate as long as peer trainers are an integral part of the team. The team could consist of other professionals within the mental health field and other content experts. Seven percent of responses reflected the belief that peers should train peers with the benefit of statewide oversight. This oversight board would include peers as well as other professionals.

Generally, these responses reflect the belief that the benefit of lived experience, either as a recipient of services or the parent or family member of someone receiving services, is necessary to transmit the basic values and tenets of peer support.

**Qualifications of Training Organizations**

When asked about the qualifications of a training organization, the majority of respondents felt that the capacity of the organization was the primary requirement. Capacity is viewed as having an adequate infrastructure in order to:

- Provide a variety of trainers in order to reflect the unserved/underserved and differing perspectives including Transition Age Youth (TAY) and older adults.
- Provide a variety of training modalities.
- Provide educational supports to those seeking certification.
- Develop core competencies.
- Develop and provide courses for continuing education units.
- Ensure on-going qualifications of trainers.
- Provide on-going training for trainers.
- Evaluate, monitor and ensure the quality of training.
Twelve percent of the responses indicate that an organization should be culturally aware and responsive. This requirement includes cultural responsiveness, language capacity and being trauma-informed. Another 13 percent felt that the organization must possess specific skills and knowledge about recovery, including a culture of recovery-orientation within the organization. Ten percent of the responses reflect a belief that the organization itself must model the values of peer support including mutuality and a non-hierarchical organizational structure.

This focus group question also asked respondents whether they thought there should be a single training entity or more than one entity providing certification trainings. Ninety-seven percent of the responses indicate that stakeholders are most comfortable with allowing for a number of training entities while having one overarching certifying body. Included in the options for training entities are colleges and universities, CBO’s (including those that are peer run) and collaborations between entities. While a variety of organizations is encouraged, most responses indicated that peer instructors/trainers should be involved in the actual training and/or operation of the organization.

Only three percent of responses reflected the view that there should be a single training entity. Stakeholders recognized that allowing for many different types of training entities would increase access to training as well as allow for customization of the training for specific county needs while maintaining a core curriculum.
Maintaining Peerness

3. How should a training and certification process ensure that peer specialists are able to maintain their “peerness”?

Meeting participants clearly felt that in order for Peer Support Specialists (PSS) to maintain their identity and job role as a peer, they must be collegially engaged with other peer providers. Forty-two percent of all responses reflected the belief that networking with and support from other peer providers is essential for maintaining the values and philosophy of peer support. Networking activities ranged from formal conferences to informal support groups. Respondents also expressed the need to be engaged with other peer staff in a manner that is consistent with the peer support value of a process orientation that allows people to share and receive feedback. The value of mutuality and respect is repeated throughout the responses within this question and throughout all of the focus group questions.

Nineteen percent of the responses indicated that the topic of “maintaining peerness” should be included in the certification curriculum as well as offered as Continuing Education Units (CEUs). Sixteen percent of the responses reflected the need to develop a consensus definition of peer support. It is felt that such a definition can not only assist Peer Specialists in maintaining their unique role but will also assist the system and colleagues in understanding and supporting their role. Other responses to this question should help to inform the system on how to
incorporate the peer role into the workforce while maintaining the integrity of the role. These include: educating existing mental health staff on the role and value of peer support, ensuring that recovery and wellness values are integrated into the workplace, addressing stigma within the mental health workplace, supporting the advancement of Peer Support Specialists into leadership roles, creating buy-in among county administration, developing a standardized code of ethics and ensuring that there is always more than one peer support specialist on a team.

How to Maintain Peerness

Qualifications of Supervisors

4. In addition to standard supervisory excellence, what additional qualifications/training/experience do you think is needed for a supervisor of peer support staff?

Responses to this question required that they be placed into five general categories and then an analysis of the two categories that received the highest number of responses was conducted. Below are the six general categories of responses from the stakeholder meetings. The majority of these responses involved specific trainings that supervisors of Peer Support Specialists should receive. Close behind is a list of general positive qualities that any supervisor should have. Forty-six responses, or 23 percent, support lived experience as a requirement for supervising Peer Support Specialists. Other qualifications include knowledge of the Peer Support Specialist role,
the ability to manage issues of inclusion and the ability to participate in a supervisors support group.

![Qualifications of Supervisors](image)

**Specific Supervisor Training Requirements**

Stakeholders reported that supervisors of Peer Support Specialists should receive specialized training in order to facilitate a good supervisory relationship. The majority of responses, thirty-seven percent, reflect the need for supervisors to **develop a management style that will create a relationship with Peer Support Specialists that is reflective of the values of Peer Support.** These values include mutuality, a flattened hierarchical structure that prioritizes relationships over the exertion of power, mutual respect and circular feedback and evaluation. The supervisor in this type of environment takes on the role of mentor and facilitates a workplace where process and teamwork are valued.

The next highest response, at twenty-one percent, is similar to the first. This training involves **the ability to create an environment reflective of wellness, resiliency and recovery values for staff.** This then would ideally be transferred to the relationship between staff and persons receiving services. Other training requirements include: receiving the Peer Certification training required for Peer Support Specialists, specific training on supervising Peer Support staff, training to dispel the myths that peer support staff breach confidentiality more frequently and have more severe boundary problems than do other staff, knowledge of the consumer/family movements, knowledge of billing for Peer Support services and cultural competence, including consumer/family member culture.
The most frequently stated qualification in the category of General Positive Qualities of Supervisors identifies personal characteristics of the supervisor, (30 percent). These include qualities that would ideally be present in all supervisors and are listed below.

### Personal Characteristics of Supervisors

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Training Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses authority well</td>
<td>Management Style Reflective of Peer Support Values</td>
</tr>
<tr>
<td>Able to tolerate multiple perspectives</td>
<td>Ability to Create a Wellness and Recovery Environment for Clients and Staff</td>
</tr>
<tr>
<td>Equanimity</td>
<td>Receive the Peer Certification Training</td>
</tr>
<tr>
<td>Understanding</td>
<td>Specific Training on Supervising Peer Specialists</td>
</tr>
<tr>
<td>Non-stigmatizing</td>
<td>Understand the Myths and Facts About Confidentiality and Boundaries</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Knowledge of Consumer/Family Movements</td>
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<tr>
<td>Knowledge of differences in learning curves</td>
<td>Knowledge of Billing for Peer Support Services</td>
</tr>
<tr>
<td>Good advocate</td>
<td>Cultural Competence</td>
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<tr>
<td>Values honesty</td>
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</tbody>
</table>

Other qualities desirable in a supervisor of Peer Support Specialist include the ability to provide support, good communication skills and empathy, encouragement of growth and advancement, knowledge and effective use of accommodations and the ability to tolerate risk.
Additional Comments and Suggestions

5. Additional comments/suggestions/questions?

This question provided each focus group with the opportunity to include feedback not already captured by the stakeholder survey, the four focus group questions or questions asked during the informational presentation. It was purposely left open to allow for maximum participation and broad inclusion of issues or concerns.

Fifty two percent of the responses represent concerns associated with integration issues, career ladder and workforce issues and certification curriculum. Integration issues refer to concerns that Peer Support Specialists (PSS) are stigmatized within the mental health workforce. Peer Support Specialists want their role to be valued and understood by existing mental health staff. They see their role as complementary to, not in competition with, other staff roles in the clinical setting. Existing Peer Support Specialists often feel isolated, unwelcomed and misunderstood by the traditional mental health professionals.

Career ladder and workforce issues are of vital importance to PSS staff. Generally, stakeholders expressed a strong need to have a career ladder that would include non-certified peer support staff. A concern exists that certification may become a barrier to employment for those individuals who do not seek certification. This would ensure an entry level avenue for employment for those not wishing to become certified. A career ladder should also support advancement beyond a Certified Peer Support Specialist or even a Peer Support job role. It was expressed that many people would like to have a career ladder that includes lateral as well as upward movement into leadership roles and non-peer roles such as Mental Health Rehabilitation Specialist and Licensed Clinical Social Worker. Additionally, concern was expressed that people with lived experience are tracked into Peer Support Specialist roles versus being given more employment options beyond working in the mental health system.

Stakeholders also expressed concern that individuals at the entry level of the career ladder have the opportunity to work in part-time positions with benefits as well as full-time positions. It was also stated that certification should lead to career advancement with salary increases and other financial benefits.

Another expressed concern is that Certified PSS’s could become perceived as a cheaper form of labor for general clinical activities, thereby losing their unique role as Peer Support. Another economic concern is that the cost of the bureaucracy to implement certification could result in fewer jobs available. However, this concern is countered by the reality that there are not enough job opportunities currently and it is hoped that certification will encourage the hiring of PSS staff.

Curriculum issue concerns fell into three broad categories. First, participants expressed a strong desire to have a process for vetting curriculum that would include stakeholder input. Secondly, a number of content areas were suggested and these have been captured in the curriculum section under the Stakeholder Survey. Third, meeting participants expressed a need for technology to
include on-line courses and videoconferencing for networking purposes for those counties that are either too small to create a critical mass for training or too rural to have ready access. The remaining items addressed in this section are listed below. Most have been captured elsewhere in this summary.
Survey Data Information
The survey was completed by 129 stakeholders, or 78 percent of attendees. Below are the survey responses.

Curriculum Type
1. In terms of training curriculum, which do you prefer?
Survey respondents were asked whether or not they preferred a core curriculum, with specializations for particular training needs, such as adult system of care, child/youth system of care, whole health, etc. or a separate training curriculum for each group. A majority of attendees thought that a single, core curriculum with specializations would be preferable.

Curriculum Topics
2. In a core curriculum, which topics do you think should be included?
The survey listed 35 topics for consideration in a training curriculum for peer providers. In addition, the survey included an “other” category where individuals could add topic areas as needed.
There were 30 additional topic areas identified under “other”. Of these, three topics received multiple recommendations: “self-care” was identified seven times, conflict resolution was identified three times and Intentional Peer Support was identified twice.

### Additional Curriculum Topic Areas Identified under “Other”

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Additional Topic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care (7)</td>
<td>Political aspects of mental illness</td>
</tr>
<tr>
<td>Conflict resolution (3)</td>
<td>Social aspects of mental illness</td>
</tr>
<tr>
<td>Intentional Peer Support (2)</td>
<td>Values of peer support</td>
</tr>
<tr>
<td>Resiliency</td>
<td>Peer leadership</td>
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<tr>
<td>Local resources</td>
<td>Disabilities</td>
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<tr>
<td>Homelessness</td>
<td>Forensic specialty</td>
</tr>
<tr>
<td>Special Education</td>
<td>Creative process</td>
</tr>
<tr>
<td>Emerging research literature</td>
<td>Maintaining peerness</td>
</tr>
<tr>
<td>Alternative models of philosophy</td>
<td>Time management</td>
</tr>
<tr>
<td>Manage up (manage your job skills)</td>
<td>Budgeting</td>
</tr>
</tbody>
</table>

### Number of Training Hours in Curriculum

**3. How many total hours of training would you recommend in a training curriculum? (a one semester college course is equivalent to 54 hours)**

In choosing the number of training hours required for training peer providers, the results are fairly close, with approximately one-third of respondents choosing “more than 100 hours”, 37% of individuals choosing “55 to 100 hours” and 26% of individuals choosing “25 to 55 hours”.

![Number of Training Hours](image-url)
Number of Work/Volunteer Hours Required

4. How much work/volunteer/internship experience should be required for certification?

Certification programs often require a number of work or volunteer hours be completed prior to receiving certification. Almost one-third of survey respondents chose “3-6 months” of work/volunteering experience and 24 percent chose “six months – one year” of work/volunteer as the minimum qualification in this area. The remaining options were all tied at eleven percent: no requirement, 20-40 hours, 40-80 hours and more than one year of work/volunteering.

Examining Requirements

5. Should there be an exam required for certification?

Though there were differences of opinion about the type of examination that would be best, a majority of participants thought an exam should be required for certification. Concerns voiced included ensuring that the exam be culturally competent, that accommodations were appropriately used and that alternative methods of evaluation be considered.
Continuing Education Requirements (CEUs)

6. How many Continuing Education Units should be required per year to maintain certification?

Stakeholders were asked to consider how many continuing education units would be appropriate to maintain certification. Almost half of the survey respondents chose “10-15 hours per year”. Another 26% thought that “15-20 hours” of CEU training would be best.

Certification Renewal

7. How frequently should the certification be renewed?

Stakeholders were asked to respond to the issue of renewal of certification and determine the time period appropriate for re-certification. In this question, 43 percent of survey respondents opted for “every two years” and 30 percent chose “every three years”.

Seventeen percent of respondents opted for annual re-certification and 10 percent thought there should not be any re-certification requirements.
Certifying Body

8. Which type of institution is the most appropriate, best entity to become the certifying body?

Stakeholders weighed in on naming the type of entity that would be best suited to oversee and grant certification. Stakeholders could choose one or more options in response to this question. Survey respondents were very equally divided among four of the choices offered: the State of California, a CYFP Peer Provider Organization, a Community College and a Community-Based Organization.

Over half the respondents chose a single entity for the certifying body.

Those who selected a single certifying body most often chose the State of California (31 percent), a CYFP Peer Provider agency (20 percent) and community colleges (15 percent). The “other” category included responses such as: the county, the BBS (Board of Behavioral Sciences, which oversees the licensure and certification of a number of professional groups), and USPRA (United States Psychiatric Rehabilitation Agency, which oversees the Certified Psychiatric Rehabilitation Practitioner (CPRP), a national certification).
Funding for Certification

9. How should certification be paid for?

121 survey respondents chose one or more of four options for funding the certification process: state MHSA dollars, the county, individual fees and other. Overall, 53 percent of responses reflect a preference for using statewide MHSA dollars for funding, 22 percent preferred using individual fees and 12 percent preferred using county funding. In addition, 13 percent identified other options, which include scholarships and grants, Department of Rehabilitation, federal workforce monies and CBO’s employing peer providers.

Overall, 48 percent of the respondents chose a single funding source while 32 percent chose two funding sources, 12 percent chose three and two percent chose four funding sources.

Further evaluation showed that of the respondents who chose a single funding source, 78 percent chose MHSA monies, 10 percent chose individual fees, nine percent chose county funding and three percent chose other. When responses from individuals choosing two funding sources were evaluated, 40 percent chose MHSA monies, 27 percent chose county funding, 23 percent chose individual fees and 10 percent chose other options.
The most common pairing was the MHSA and county funding, chosen by 46 percent of respondents. Next most common combination was the MHSA and individual fees, chosen by 26 percent. The third most common combination was the MHSA and other sources, chosen by eight percent of respondents.

**Grandfathering-in Recommendations**

10. What should be the policy regarding certification for all those who are currently working as Peer Specialists within the mental health system?

There are many peer providers currently employed within the county mental health system, community-based organizations and peer provider organizations. Stakeholders were asked to weigh in on the concept of grandfathering people in regarding certification.

Survey respondents were fairly equally divided among the top two choices: “a minimum of one year’s experience” and “having a set number of years of experience plus three letters of recommendation” (39 percent and 36 percent respectively) and equally divided among the other two choices: “no experience requirement” and “a minimum of five years of experience”. (13 percent and 12 percent)
Mechanism for Billing Medi-Cal

11. Which mechanism for billing do you think should be pursued? Check all that apply.

Stakeholders were asked to identify which Medi-Cal billing mechanism they thought should be pursued as part of certification. Survey respondents could choose one or more of the options listed. Overall, 35 percent of respondents chose using the current billing mechanism under the rehabilitation option. Twenty-nine percent chose certifying the provider, 19 percent chose certifying the service and 17 percent chose certifying the site.

A further analysis of the responses shows that 55 percent of respondents selected a single option for billing Medi-Cal. The remaining 45 percent chose two or more of the options, with 13 percent choosing all options.

Of the respondents that chose a single option for Medi-Cal billing, 55 percent chose utilization of the current billing mechanism under the rehabilitation option, 26 percent chose certifying the provider, 10 percent certifying the service, seven percent certifying the site and two percent choosing not to bill Medi-Cal at all.
The analysis of the responses to this question reveals a very mixed picture. There is a need for further stakeholder information and discussion as pointed out in the recommendations.

**Wrap Up of Stakeholder Meeting**

The stakeholder meetings wrapped up the day with a discussion of identified barriers, challenges and solutions. Many of the themes brought up were reflective of the conversations that had occurred during the day. Some points that were highlighted are interesting to review and instructive of next steps to be taken.

**Barriers and Challenges**

When comments were tallied, the most common barrier identified was the lack of employment opportunities, which is often due to larger, systemic issues in relationship to hiring Peer Support Specialists. A significant barrier is the lack of funding for a project as large and comprehensive as certification. Curriculum issues, such as determination of the number of hours required, identification of content areas and access issues for small and rural counties, will need to be addressed. The issue of state-wideness versus a county-directed approach was recognized as problematic in relationship to statewide certification. In terms of Health Care Reform, stakeholders recognized the importance of being included in discussions and planning for the future. Additionally, concerns were expressed about the possible negative impact of billing Medi-Cal for peer-provided services, general barriers to certification, evaluation through an examination and stigma in the mental health workforce.
When the barriers in current practices were analyzed further, the two most important issues to contend with are lack of job availability and civil service barriers to employment. Many people indicated that certification alone will not ensure that there are positions available within county mental health systems. Other issues for consideration include lack of acceptance from traditional mental health staff, a belief that peers shouldn’t work, general philosophical concerns, lack of respect for peers, lack of knowledge about peer services, using peers as a cost-saving measure and concern about working in a medical model environment.

Solutions
In addition to identifying challenges and barriers, stakeholders outlined potential solutions. The solutions are grouped below.

Job Availability Solutions
- Require that county contracts with the state include a set number/percentage of Peer Support positions.
Financial Solutions
- Utilize MHSA/Workforce Education and Training monies
- Redirect some of the millions of dollars currently allocated to other guilds, such as social workers, to fund certification
- Utilize revenue generated from billing for peer services
- Provide scholarships

Medi-Cal Billing Solutions
- Incorporate Quality Improvement Departments in the discussion of Peer Support.
- Educate mental health providers about recovery and resiliency oriented treatment planning to assure that treatment plans are strengths-based and compatible with recovery and resiliency.
- Integrate peer services into the treatment plan.

General Certification Solutions
- Look to the state and nationally for organizations with existing infrastructure that can take on the issue of peer provider certification.

Statewideness Solutions
- Use the opportunity of this coming year to prepare for creation of a state plan amendment that would outline the essentials of peer certification.
- Educate mental health directors about certification and employment of peers.
- Use templates regarding job descriptions and policies that have been created successfully in other similar fields.
- Create curricula standards broad enough to allow multiple curricula to be vetted for certification of peers.
- Create an authorizing body that prepares trainers.

Stigma Solutions
- Join in on events that celebrate disclosure of lived experience, such as National Coming Out Day or the Up to Us Campaign.
- Create safe environments for mental health professionals to disclose lived experience. Train the workforce to welcome and value peer providers.
- Share recovery stories.

Exam Solutions
- Create alternative evaluation methods such as oral exams.
- Utilize accommodations to enhance success in taking the exam.

Critical Decisions for Implementation Planning
The stakeholder process included an analysis of existing national certification efforts as well as a description of current practices in California regarding the hiring and training of Peer Support Specialists. These findings were included in a report entitled, Certification of Consumer, TAY.
Family and Parent Peer Providers, A Review of the Research. This report included a summary of critical decision points necessary for implementation planning. The stakeholder meetings provided some key information on values as well as clear direction for future planning. In an effort to capture relevant information from the stakeholder meetings in relationship to these decision points we have included the outline from the report here. Where information gathered from the stakeholder meetings intersects with these decision points, it has been included within the outline.

Stakeholder Input Regarding Critical Decisions for Implementation Planning

1. **Identification of a Certifying Body**
   While the information from the survey appears mixed on who should be the certifying body, an analysis of those restricting themselves to one response shows that choosing the state through an existing entity such as the BBS or the Department of Health Care Services would be an acceptable choice.

2. **Infrastructure Needs**
   The stakeholders clearly felt that the capacity to manage the various functions of a certification process was a key priority in choosing a certifying body. These functions include the ability to manage the multiple functions of certification including, but not limited to, authorizing training entities/trainers, establishing eligibility and granting certification, auditing Continuing Education requirements, managing complaints and possible ethical violations and certification renewal. The cost of such an infrastructure was a major concern and it was felt that utilizing an existing state body with existing capacity would be the wisest choice.

3. **Training**
   Stakeholders provided information on a variety of issues related to training.
   - A minimum of 55 hours of training should be required. Thirty two percent of stakeholders felt that 100 hours or more of training should be required.
   - A variety of training organizations qualified to provide training is supported by stakeholders. Additionally, partnership between educational entities and CBO’s is encouraged. Generally, stakeholders reported that variety of training entities should be encouraged to allow for ease of access as well as meeting the needs of individual counties.
   - Training entities should meet a number of qualifications (see Qualifications for Training Entities) in order to best serve certificate recipients as well as those receiving services.
   - Trainers with lived experience themselves is highly valued and should be a deciding factor in choosing training entities.

4. **Core Curriculum**
   Stakeholders believe that there should be a core curriculum for all Peer Support Specialists with specialized curricula tracks for the type of peer provider as well as specific areas of specialization including health care, trauma informed care and forensic services. Stakeholders also reported that peers themselves should be involved in
determining content areas for curricula. It was also felt that multiple curricula could be utilized if core content areas are established and each curriculum is reviewed to assure that these content requirements are met. This allows existing curricula to be used and allows each county to individualize training to their specific needs.

5. Core Competencies
Stakeholders felt that the development of standardized core competencies for Peer Support Specialists is critical. Peers should be integrally involved in the development of these core competencies. Additionally, a code of ethics should be developed or an existing code adopted.

6. Measurement
Stakeholders strongly believe that an exam-based certification is appropriate. However, it will be important to include alternative forms of testing beyond that of a written exam. Oral testing should be an option and educational supports and accommodations should be provided.

7. CEU’s
The majority of stakeholders stated that Certified Peer Specialists should receive between 10-15 hours per year of continuing education units to maintain their certification. Meeting participants stressed the importance of including the topic of “maintaining peerness” in course offerings.

8. Meeting CMS Guidelines
Stakeholder comments regarding care coordination indicate a concern that current treatment planning practices may not be consistent with the philosophy of person-centered and parent/family driven care. Stakeholders are hopeful that current efforts to train existing mental health staff in implementing wellness and recovery and resiliency oriented treatment plans will create an environment where peer services can be easily incorporated within a holistic service plan. Additionally, it is felt that certified Peer Specialists should be included as providers able to work with clients and family members in developing treatment plans.

With regard to supervision, meeting attendees stressed that individuals who supervise Peer Support Specialists should be able to develop a working relationship that is based upon the values of peer support and wellness and recovery principles. These are discussed in this paper under Qualifications of Supervisors. Additionally supervisors should have specific training geared toward developing a good knowledge of the peer role and how to supervise peer support specialists. Having lived experience is also highly valued in a supervisor.

9. Options for Medi-Cal billing
Based upon responses to the survey, most stakeholders felt that utilizing the current rehabilitation option for Peer Support Specialists to bill Medi-Cal was preferable. However, verbal responses during the stakeholder meetings indicated that stakeholders generally supported the use of at least four options: certifying the provider, certifying the
service, certifying the site and utilizing existing ability to bill under the rehabilitation option. There were expressed concerns that certifying the provider or service could result in lower billing rates. Stakeholders felt that a lower billing rate would be a disincentive to counties and therefore counties would not favor these options.

The results may also reflect the complexity of the issue. A key factor that could have affected stakeholders’ opinions is the lack of knowledge about the options themselves, the nuances related to choosing more than one option and the intended and unintended consequences of choosing one option over another. Going forward it would be necessary to utilize content experts to delve more fully into these issues to allow for a more informed decision.

10. Funding and Sustainability
Stakeholders strongly support the use of Mental Health Services Act (MHSA) money to support the administration of a certification program as well as to pay for individual fees through stipends and grants. State level MHSA monies are currently used to fund a variety of financial incentive programs targeting graduate level degrees related to mental health.

11. Partnering with State Entities
Stakeholders agreed that creating partnerships with key state entities is essential to forward progress on the path of certification. Decision-makers at the state level are important to include in discussions. Stakeholders felt that regular communication with groups such as the California Mental Health Directors Association, the Department of Health Care Services and California Center for Medi-Caid Services would enhance the buy-in and ease the process considerably.

12. Employability
Stakeholders expressed concern about the lack of availability of jobs. Certification without employment opportunities creates disincentives to embark on the rigorous process of becoming certified. Several factors mentioned by stakeholders relate to the need to prepare the current workforce for the inclusion of peer providers: lack of understanding about the role of peer providers, lack of belief that peers should be working, philosophical concerns and a lack of acceptance from traditional mental health staff.

Stakeholders ranked civil service barriers second among the top two barriers to employment of peer providers. This will require ongoing attention and problem-solving to address issues such as a lack of appropriate coded positions to accommodate these new employees, restrictive hiring practices and union concerns about practices such as “bumping”, where seniority plays a significant role in determining lay-offs.

Partnering with Human Resources was also mentioned as an important way to address the problems related to hiring practices, the creation of job descriptions and clear policies and procedures related to the employment of peers.
13. **Career Ladder**
Stakeholders discussed the need for career ladder opportunities and suggested creating step levels within the Peer Support Specialist classification as well as articulating the career ladder moves laterally and upward through other classifications. Stakeholders also suggested that opportunities for advancement may be increased through assuring that Peer Support Specialists can produce revenue through the ability to bill Medi-Cal for services. Generating revenue for the system is a potential factor that could influence the value placed on these positions.

14. **Portability**
In order to have portability across county lines, county mental health directors must buy in to the certification standards that are developed and vet the training as able to produce qualified individuals for work in the mental health system. Some stakeholders have mixed feelings about the statewideness of certification. In order to have portability, the county mental health directors need to come to an agreement about this issue.

15. **Rural and Small County Issues**
Representatives from small and rural counties expressed concern that statewideness may be problematic if there isn’t good participation and input received from their constituency. Stakeholders confirmed the importance of issues such as difficulty accessing trainings. Small and rural counties often do not have a critical mass of peers to be trained. Transportation is a difficulty as well. Concern was also expressed by small counties who had invested considerable time and attention in development of their own peer provider trainings and whether their work would be vetted in a statewide process.

16. **Health Care Reform**
Stakeholder recognized that Health Care Reform offers great opportunities for Peer Support Specialists going forward and see the need to include healthcare content into the core curriculum and/or develop specialty curricula to prepare Peer Support Specialists for these new positions. A key concern is that stakeholders are included in the discussions happening at the state level with regard to the upcoming implementation of Health Care Reform.

**Question and Answer Sessions**
During each stakeholder meeting, there were three opportunities scattered throughout the PowerPoint presentation to ask questions, seek clarification and provide input. Each of these sessions was transcribed and is presented by stakeholder meeting in Addendum I.
Recommendations

The recommendations that follow are based upon the input from participants in the Stakeholder process. This should not be considered an exhaustive list as new information and input from other interested parties and experts will necessitate on-going revision of plans and recommendations.

1. Develop a statewide certification for Peer Support Specialists that will legitimize peer support as an effective and necessary service to clients and family members.
   a. Training should consist of a minimum of 55 hours.
   b. Develop a standardized set of core content areas for curricula for all PSS’s with specialty modules to meet the specific needs of the consumer/survivor, TAY, family and parent specialists, as well as specialized content areas.
   c. An exam should be required with adequate educational supports including alternative evaluation techniques including a verbal exam.
   d. Establish a work/volunteer experience requirement of three months to one year.
   e. Establish a CEU requirement of 10-15 hours per year to maintain certification.
   f. Re-certification should be done every two years.
   g. Allow for a grandfathering process to include at least one year of full-time equivalent work and three letters of recommendation.

2. Include Peer Support Specialists, (PSS) as a provider type within the State Plan for Specialty Mental Health. Allow for maximum flexibility in what PSS’s can bill for including, but not limited to, peer support, rehabilitation services including group and individual, collateral, recovery planning, strengths based assessments and targeted case management.

3. Include in the State Plan an option for peer-operated agencies to provide an array of mental health services, including peer support, which can be billed under Medi-Caid. An option to allow stand-alone peer operated agencies to specialize in and provide only peer support services should be included as well.

4. Request that the county mental health directors adopt whatever statewide requirements are developed for certification and billing practices in order to avoid individual counties adding requirements beyond those specified by the Centers for Medicaid and Medicare and the Department of Health Care Services.

5. Develop a statewide definition and code of ethics for Peer Support Specialists.

6. Evaluate the possibility of broadening the definition of “service recipient” to include parents and family members of individuals receiving services so that peer support services can be documented and billed more directly and clearly.

7. Develop a plan for funding a certification process utilizing Workforce, Education and Training monies from the MHSA.
8. Address the concern that current practice of documentation for billing may not be aligned with the values and principles of peer support and a wellness, recovery and resiliency orientation.

9. Provide extensive and expansive training on the values, philosophy and efficacy of peer support to mental health administration and clinic staff.

10. Develop a policy statement regarding the importance of maintaining the integrity of peer support as a mechanism for avoiding the potential incentive to drift from peer support to providing services in a more traditional manner as well as utilizing PSS’s as less expensive labor for other clinical duties.

11. Develop a state-wide solution to deal with civil service barriers to the employment of PSS into specified coded positions.

12. Address the problem of lack of employment opportunities for PSS’s by establishing a statewide workforce minimum to comply with the intent of the MHSA.

13. Develop career ladders for PSS’s that begin with non-certified PSS’s and create lateral as well as upward mobility including leadership positions. Develop state-wide models that can inform county leadership.

14. Create welcoming environments that embrace the use of multidisciplinary teams that can incorporate PSS’s fully onto mental health teams.

15. Select a single certifying body to implement and manage the certification of PSS’s. The certifying body would preferably be an existing state body or a statewide agency that represents Peer Support Specialists.

16. Develop standards and oversight for training providers. Trainers must either be individuals with lived experience or a team of individuals that includes people with lived experience. Ensure that a number of training organizations and/or collaborations of training entities would be eligible. Ensure that these organizations have existing infrastructure to support the considerations expressed by stakeholders in the “Qualifications of Training Organizations”.

17. Develop a policy to establish qualifications for who may supervise Peer Support Specialists. Stakeholders clearly prefer that people with lived experienced provide supervision. However, due to capacity issues the remaining qualifications may have to suffice. These include specific training for supervisors as well as the presence of personal characteristics that align with peer support values and philosophy.

18. Develop a policy that supports the importance of PSS’s maintaining their “peer” role. This will involve creating networking opportunities, both formal and informal to allow for the profession itself to grow as well as to allow PSS’s to maintain and hone their professional values and principles.
Addendum I

Regional Forum on State Certification for Consumer/Youth/Family Parent Peer Support Services - Central Region 3.23.12

Questions and Comments Central Region
Section I

1. Grandfathering in? What will happen?
2. Legitimacy word is offending – feels that people are past that. Be careful of language used when discussing it. Really what we want to assure is the quality of service and expertise.
3. Supervision – would qualifications be written in the amendment?
4. Peers can bill now for services under the Rehab Option.
5. Job descriptions
6. Why is the TAY certification separate from a consumer certification? There is a felt need for youth-generated, youth culture-oriented services and skills.
7. How will people who are coming out of the legal system be able to be used? Howie the Harp organization offers a Forensic Peer Specialist Certification. May be used as an example of how to do it.
8. The system of amendments and waivers has been going on a long time. How long do they take to take effect? Once approved, a date is set. Not sure how long it takes to get an amendment through the process. Been told that a window of opportunity in California will be within the next year or two. Time to start the work is now.
9. Look for a better way to describe Forensic peer specialist.
10. The county has flexibility about who bills. One example, Community Action Marin is peer-run and contracted with Marin County, and bills under rehab services.
11. Eleven counties (that we are aware of) currently bill Medi-Cal for peer services
12. Do peer providers need a National Provider Identification (NPI)?
13. Overmatch situations – needs additional scrutiny.
14. Providers (CBO’s) may also choose not to bill for peer services.

Section II

1. Licensed/unlicensed
2. Are the peers that are doing billing working directly for the county or CBO’s? Both are true.
3. Are peers who bill doing this under a clinician? Treatment plan is the basis for billing for any provider.
4. Other qualified provider must meet the minimum qualifications of being 18 and having a high school diploma.
5. Why certify? Might be able to assure that peer services are provided in a recovery-resiliency oriented way.
6. You could create a peer provider that does not require a high school diploma.
7. May raise the bar for all services to be more recovery and resiliency-oriented services.
8. MH directors can set the standards for the county. If you set the competencies and standards and create a whole package for directors to be able to mitigate the risk, this can help. They do not HAVE to accept certification, but it will help.

9. Is there a plan they can be forced to accept? No, and probably it is best that people do have choice and a good working relationship.

10. In California, there is no Medi-Cal definition of peer provider. Counties however are hiring people as peer providers.

11. Changes will be happening as we change to the Department of Health Care Services. They need to be at the table and have been invited to be partnering in these discussions.

12. Be willing to update language and use language in a sensitive manner, respectful.

Section III

1. List of reported job requirements is on pg. 23 of the research paper. Lived experience plus recovery is one example of a job requirement – what does this mean? One county only stipulated the need for demonstrated recovery plus lived experience.

2. Some counties do want to see documentation that you have received mental health services as a job requirement.

3. Pillars of Peer support reports can be found at pillarsofpeersupport.org or use Network of Care, which has a link to the report.

4. Why include the MHSOAC? Aren’t they just MHSA? Their role is broadening and can be a helpful advocacy group in this effort.

5. Include California Office of Statewide Health Planning and Development (OSHPD)

6. Could Health Care Reform dismantle what we have?

7. Are Primary Care Providers (PCP) going to be retrained? It’s required that they receive mental health and substance abuse training.

8. Health care reform is being implemented in Fresno. They did a survey of Peer Providers to find out what they need for training.

9. Health care reform needs to be on people’s minds as we approach the task of certification. May need training to work in physical health care settings. May need a specialty curriculum for this kind of employment.

10. Not sure how the funding for training is being drawn down.

11. What is the availability of jobs? Can certification ensure that people will have jobs? We need to find out about the need for peer providers. Need to educate employers about the benefits and competencies of peers to increase peer provider positions – this might be done through a guild organization.

12. Coordination of health care – a morbidity study that consumers are dying ten years younger than their non-consumer peers. Wants to reduce the morbidity rate and increase of health of consumers. (Mortality and Morbidity Study).
Questions and Comments Greater Bay Area Region

Section I

1. Would the payment of peer provided services be less than other rehab services? Yes, it is likely that peer services would be paid at a lower rate.
2. The lower rate is a push and pull. One of the things we wanted is to have peer services legitimized. Peer support services are different, based on connecting, vs. traditional services which are assessing and objectifying.
3. Essential to have peer provided services called out to provide validity for the wider range of services than falls under Rehab Option.
4. Creation of a distinct service is different from creation of a distinct provider type.
5. Sites can bill for services as well as do non-billable services.
6. If health care reform goes through, more managed care entities will come in to be the provider of mental health services. OptumHealth is an example, working in San Diego.
7. If you are not certified as a Medi-Cal provider (as an agency for example), you can’t bill.
8. Potential issue with acting as a peer provider and other qualified provider at the same time.
9. Provider sites can be defined as having peer providers and peer services – can be creative due to the flexibility in the negotiation.
10. Could peers bill as private practitioners? Any group that wants to practice privately has to be done through legislative action.
11. Can we look at the satisfaction level of people who went through the different types of training before deciding on what’s best here?
12. Has there been any research on the success of different types of certification programs?
13. We can have a problem with the need for CEU’s when what’s available is not recovery-oriented, more clinically focused. Potentially losing peerness.
14. How can we mold designations like MHRS, to be more peer-friendly? Definition of Other Qualified Provider is what peers currently fit under. The only qualifications that it requires are 18 years of age and a high school diploma.
15. How would malpractice insurance be handled with peer providers? If you are employed under an agency, they hold the insurance.

Section II

1. Alameda is billing Medi-Cal with peers as well through Fred Finch.
2. Some groups in Alameda do not bill.
3. Contra Costa, Solano, San Francisco, Sacramento CBOs do bill Medi-Cal
4. There was a time when co-signatures were required for Other Qualified Providers. These do not exist from DMH at this time. Counties may require it.
5. “Supervision” does not mean the supervisor has to sign off on every note.
6. Rehab services are listed in the research paper, pg. 16. All services are listed.
7. If we set it up in Medi-Cal, private insurance may follow suit.
8. Can we take some political action to help this process? The CA Association of MH Directors has invited WWT to come in to begin the discussion. This includes CM

Section III

1. Think about using the training from the department of developmental services training that exists for direct service workers.
2. Where did WRAP go in the categories? It falls under specific practices.
3. Accessibility of training needs to be considered especially related to cross disabilities and people below the poverty level.
4. Transgendered people need to be included in training and curriculum.
5. We need to foster the process of becoming a “peer” by experiencing the process through groups and owning your own journey and be able to model it. Not so much a knowledge base but an experience base.
6. Need to maintain the value of peer leadership and peer run training. It is about the process of recovery perhaps that can be built into the CEU process or on-going support.
7. Important to be able to include dual diagnosis population for drug and alcohol.
8. Which counties require training before hire?
9. How do the three terms of individual, group and crisis terms of scope of practice relate to current regulations and/or definition of peer support.
10. How many counties are using existing codes as this is dangerous because peers get bumped out of jobs.
11. Sometimes creating new codes can result in creating lesser paid jobs for similar work.
12. Tests should be given with options for oral, written, literacy level etc.
13. Want to evaluate how to develop a testing system to accommodate inclusiveness.
14. Can certification be set up to guarantee employment with county services? It is an advocacy effort. The certification needs to be something people can trust.
15. Working in primary care is going to happen even without healthcare reform. Training programs are already being researched. Integration of primary care and mental health will happen. Good to be prepared.
16. TAY perspective: Understand culture changes and gender gaps. Important also to have an adult ally as a mentor.
17. It’s co-mentoring, because TAY experience is also important to value.
18. Diversity in California can be inclusive of the community experience. Part of our learning experience should be shared. Young people don’t have to go through the hardships that we did. Need to make supported employment available early. Be inclusive of the community need when considering certification.
19. Possibility of waiving elements in the certification process, due to lived experience, challenging the requirements, etc.
Regional Forum on State Certification for Consumer/Youth/Family Parent Peer Support Services - Southern Region 4.13.12

Questions and Comments Southern Region

Section I

1. Clarification needed between provider type and service type. Provider certification is related to the individual. Service type means that Peer services are defined and then the state decides who can provide these services.

2. Family support is provided to the parent. The service recipient is the child. Billing collateral services gets convoluted. If Peer Support is defined, then it could have a code for providing these services (not having to relate the note to the child). Complications of what gets written in the child’s file (parent issues, for example).

3. Certification standards: supervision is related to post-certification.

4. In county mental health systems, the MH Director is the ultimate supervisor of all staff.

5. Who does the supervision? They use “Qualified MH Provider” – defined differently, includes Peers who are trained to be supervisors.

6. In California, does the state require supervision by a licensed staff person – no.

7. In other states, supervisors are licensed but required to go through the Peer Training.

8. The timing is very good for this process. Don Kingdon, thinks a window of opportunity will be about one year.

9. Comment – it is very important to have a peer supervisor. Someone who knows the services provided by peers.

10. There should be a statewide system. Many counties have done a lot a good work on this. States don’t like to open up the state plan too much. Seems important to “strike while the iron’s hot”. MH Directors have signed off on the general issue. Not sure what exactly they would be willing to do.

11. If you create a new service called peer support services, you will need to go through a rate setting process – likely to be paid less than other services.

12. You can do more than one option: peer provider, peer services and peer sites.

Section II

1. Which counties have higher qualifications for “Other Qualified Provider”? Some counties do not use OQP. Used to be that notes have to be co-signed. Not required by the state, but some counties still do this.

2. How is a warm line billed? Could be done, but the county is currently paying for the service out of another pot of money.

3. Not all good services are billable. Medi-Cal is an insurance program. There are services that can be billed and this provides revenue.

4. If the county is integrating physical care and mental health care, they should find a way to bill it. Physical health care is very familiar with and supportive of peer services.

5. Social skills are already billable.
6. Concern about screening re: certification so people don’t get screened out. Barrier for employment is civil service rules. Each county has different regulations. The state has to deal with these issues, potentially through legislation.

7. Concern that the state would be the one to provide regulation of the above issue. San Diego has worked it out successfully on their own. Whoever works on this issue needs to be skillful and inclusive of forensic backgrounds. For example, might suggest that the employer may not look back more than three years.

8. County Council may be involved in the decision to hire.

9. Inclusion of people with forensic backgrounds needs to be done. So important for peers on these backgrounds.

Section III

1. Did all of the counties have experience as a requirement? No - some had no experience at all. We will need to adjust the PowerPoint.

2. NAMI has a training program for people in the adult system.

3. Recovery Innovations (RI) has done a training for TAY.

Section IV

1. Riverside County has a monthly peer support meeting. Uses Keeping Recovery Alive, 52 topics. Allows people to connect and bring up questions/issues.

2. Recovery Innovations, CA (RICA) does a monthly meeting for all peer providers, run by peer providers.

3. Certification can create professional stigma, about what your “level” of peer is.

4. Certification has allowed me to use a language that reinforces being a peer.

5. Language is very powerful in maintaining peerness.

6. Are we looking at educating the system – understanding peer support. This is an important aspect of what’s needed.

7. People need to be educated about being in a still traditional mental health system.

8. Remembering who we are – and official statement that reinforces peerness.

9. Make sure that wherever I go, I can take any position and still maintain my peerness.

10. Family members want to see growth, and the higher you go, it is a good role model.

11. You can speak both languages – system and peer. Reality is that they have to speak the system’s language for promotion within the system.

12. County supporting two people in masters’ programs through 20/20.

13. Never met a consumer/family member who weren’t supportive of the services provided by peers. More issues with colleagues in the system. Educate the staff.

14. Hardest part of job as a family member supervisor is the attitude of other staff.

15. NAMI Provider to Provider course educates the providers.

16. Ensure that peer providers learn and value the other providers too.

17. Knowing each other’s roles, teamwork and conflict resolution.

18. Team-building within each organization is needed.
Question and Comments Los Angeles Region

Section I

1. This movement is seeking a statewide standard. Certification that is defined as including the ability to bill. The issue is that in California, the MH Director will still have the authority to determine what happens in his/her county. Important to get the MH Directors on board.
2. There is no state requirement that the state requires that notes by peers be signed off. MH Directors may still require it as a risk management measure.
3. Peer providers are not more likely to bill inaccurately for services than other providers.
4. Have there been people who have opposed peer certification? Yes, some are concerned about the requirements of billing and that this will degrade the provision of peer support services.
5. Concerns about how to do billing for peer services in the child/youth system.
6. Community colleges are also an option for a certifying body.
7. Who should be a training body? Will be a focus group question.
8. Will all peer services have to be billed for? Could other services be added to the definition of peer services? This could be defined in the state plan.
9. Many states have created stand-alone peer sites billing. In LA, currently only sites that have ALL services can bill for peer services as well.
10. What about people working with clients who are not involved with the rest of the system? What would care coordination mean?

Section II

1. Is there resistance to billing for peer support? What is it? Mostly seems to be a lack of knowledge and risk management.
2. Some administrators have created mechanisms to support billing by peers.
3. Felt sense is that professionals devalue peer services. Devalue unlicensed people working in the field.
4. Education of the workforce regarding the role of peers. Education regarding the value of peers. Not in competition with professional workforce.
5. Concern about the word “recovery”. It is a long road. Concern about the lack of opportunities. Certification needs to look at the career ladder possibilities.
6. Have clinicians or doctors been against certification? Not in these meetings, but most likely it does exist in some places.
7. The question about billing implies stigma about the capability of people with lived experience.
8. One example: Clinicians were positive about peers doing welcoming in the clinic.
9. Riverside County has a very strong peer support network. Struggling with licensed staff who are worried that peers will take jobs. Supporting certification to legitimize the important work that peers are doing.
10. A lot of peers are being trained to get licensed. This will be another way to change the system.

11. Need for more research to provide additional validity of peer services. Yale is doing some work. Michigan has done some great work.

12. Important to remember that lived experience is the basic reason we are here today.

13. What about getting away from use of the word peer, which creates barriers.

Section III

1. Disclosure of lived experience can be a barrier due to HIPPA requirements.
2. A problem can occur when hiring partners if they don’t really have lived experience.
3. How were people being hired? Part-time/full-time and living wage. This should be a consideration when developing codes and jobs.
4. There are some places that are requiring volunteer work before hire. Is this a general practice? (Riverside) There are people being hired and then are in training for a year before being hired into real positions. This is not being done with any other codes in the County (Riverside).
5. How is lived experience defined across the State? Does it require public system experience? Or some other requirement.
6. For a lot of peers they have not worked for a long time but people are now being hired. Peer training should include things like how to do interviews, self-care, how to deal with stressful situations, how to work co-workers and supervisors etc.
8. Have to address stand-alone peer sites.
9. Medical groups are focused on education and insist that doctors in the group. Groups that have the best outcomes do not have professionals in the group.
10. Important to look at how peer services are being delivered in CBO’s and peer operated centers. Peers being used in non-peer ways. Some mechanism of oversight is necessary.
11. Peer hired in a contract agency that was told not to get her coffee at the staff coffee pot.

Additional questions/comments

1. Once the certified peer specialist curriculum topics/competencies have been finalized for CA, will there be an open bid process for organizations to be selected as contractors to provide the state certification training? If not, who will provide the state training and what will happen to our many peer organizations throughout the state that currently provide peer trainings within and required by their counties?
2. Will ALL peer services provided in CA have to be billed to Medi-Cal? For example, some peer services may compromise the very essence of peer provision if the service is based on Medi-Cal’s definition of medical necessity. I’d hate to have only Medi-Cal billable peer services and/or endanger MHSA funds which allow for more flexibility to some of our peer services (endanger because all peer services become Medi-Cal billable and MHSA funds currently used for peer services are freed up for other non-peer services/programs.
3. How will we ensure cultural and linguistic diversity within some of the certification requirements such as testing and training diversity?
4. What will happen if certified peer specialist’s certification becomes national vs. state-driven? This has been in discussion for over three years and there is still movement at the national level to adopt national certification standards – can the presenters comment on how what we are doing on CA is aligned with or can contribute to this national certification movement?
Regional Forum on State Certification for Consumer/Youth/Family Parent Peer Support Services - Superior Region 4.27.12

Questions and Comments Superior Region

Section I

1. Movement towards integrated care re: alcohol/drug services – some things cannot be billed in alcohol/drug services. How will this be dealt with? Important to deal with the billing issues.
2. The integration of alcohol/drug services is uneven. Documentation and tracking continues to be separate and distinct. Have a ways to go with complete integration.
3. Can this be in the discussion in this next go round on state plan amendment?
4. Alcohol/drug has much more stringent requirements on confidentiality which must also be dealt with.
5. What would training/credentialing look like? What accommodations might be put in place?
7. Certifying bodies: what about community college certificates? Certificates are not an AA. Need to work with community colleges to make sure that the certificates that articulate to further education. Make sure the credits are transferrable.
8. Community college option is a lot more relevant for rural areas.
9. How long in remission/recovery does a person have to have in order to be a peer provider? There was not a clear definition. People tended to show “being in recovery” as having a WRAP and/or, disclosing and using your story, finishing a training program, as adequate demonstration of recovery.
10. You can provide peer services if you have other credentialing – must be willing to share your story.

Section II

1. Is being able to bill really “peerness?” Does billing for services change the relationship because documentation is required? Definition is very important – mutuality that creates change for both recipient and provider. Important to have different requirements that allow this uniqueness to be reflected in documentation.
2. Hire for peer support and then have peers bill for standardized mental health services. Not really validating pure peer support without a peer service type definition.
3. Is a better model to have people with lived experience join the mental health workforce or contractors that do not fall under the umbrella of county services.
   a. A false choice as peers need to be infused in the county system
   b. More peer organizations are needed
4. Each peer provider’s experience is unique. Important not to have a power relationship by billing.

Section III

1. Integration of primary care and mental health: while it looks on paper that primary care has adopted peer support, it is only in the support group arena. It’s not direct services.
2. Solano is training receptionists, waiting room personnel, to be welcoming.
3. Another challenge with integration is that the medical providers are medical model driven vs. rehab and recovery. A lot of resistance among medical practitioners to integrating with mental health.