Certified Peer Specialist (CPS)

Providers contracted for this service are expected to comply with all requirements of these service-specific performance specifications.

Certified Peer Specialists (CPSs) are individuals currently in sustained mental health recovery or who have lived experience with behavioral health disorders and have been certified to help their peers with a similar experience to gain hope, explore recovery, and achieve life goals. CPSs may, in addition to having a history of a mental health disorder, have a co-occurring substance use disorder. CPSs are actively engaged in their own personal behavioral health recovery and share real-world knowledge and experience with others who are on their own recovery path. CPSs use self-disclosure in a safe, ethical manner and may serve as mentors, advocates, and facilitators for Members. A qualified CPS must meet Executive Office of Health and Human Services (EOHHS) requirements including completion of training and certification by an agency approved by the Department of Mental Health (DMH).

The primary responsibility of CPSs is to support the voices and choices of the Members, establishing a mutually supportive relationship, using a strength-based approach, and sharing experience and inspiration about recovery, community inclusion, and accompaniment, thereby minimizing perceived/potential power differentials as much as possible. The focus of the CPS role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery by linking Members to a recovery community and serving as an individual guide and mentor.

Members can access CPS services through all components of Community Behavioral Health Centers (CBHC), including Community Crisis Stabilization (CCS) and Mobile Crisis Intervention (MCI) components, and through Community Mental Health Centers (CMHC). CPS services can be accessed by Members based on medical necessity and a referral by a medical or behavioral health provider, or other Care Manager who has contact with the Member and is able to identify the need for CPS services.

CPSs are employed by CBHCs or CMHCs. For entities (e.g., CBHC, CMHC) that offer CPS through subcontracted arrangements, the contracts between the CMHC or CBHC and the entity providing the CPS must be wholly overseen by the CBHC or the CMHC. In addition, the contract must reflect that the CPS provided by the contracted entity meet all EOHHS requirements for training and certification and establish proper oversight mechanisms to ensure performance and quality expectations are met.

Components of Service

1. The CPS will form a connection with the Member and act as a mentor, coach, and supporter to facilitate the Member's journey toward wellness. This may include:
   a. Providing emotional and social support with an overall goal to instill hope for the individual's future and quality of life;
   b. Helping the Member try new strategies for developing wellness-supportive friendships, reconnecting or improving family relationships, and identifying and using wellness-oriented and other community networks;
   c. Acting in an open and transparent way as a role model and living example of a person who works on maintaining wellness;
   d. Providing linguistically appropriate and culturally sensitive mental health peer supports that embrace the diversity of the Member's identity, including racial, ethnic, sexual orientation, gender identity/expression, physical and intellectual challenges, and the Member's chosen pathway of wellness;
   e. Assisting the Member's process and supporting the Member's goals and decisions; through providing services in a person-centered and strength-based manner; and
   f. The CPS may use evidenced-based practices from trainings, to support the Member's growth in consultation with the Member and with consultation and support from supervisor.

2. The CPS will help the Member form self-advocacy skills by supporting the Member's awareness and understanding that they possess their own wellness capacity. This may include:
   a. Sharing wellness experience and using coaching and mentoring techniques to support a Member's awareness and understanding that the Member possesses their own wellness capital and can work on sustaining their wellness;
   b. Supporting the Member in making positive life changes and developing skills to facilitate their wellness; and
   c. Serving as an advocate for and with the Member and assisting the Member in learning self-advocacy and life skills.

3. The CPS will assist the Member in creating meaningful links by acting as a wellness liaison to the medical and mental health treatment system, social services, and other systems with which the Member interacts. This includes:
   a. Assisting the Member in creating personally meaningful links to wellness opportunities in the community, accessing other community support services, connecting to vital resources, continued healthcare, accessing/maintaining housing, job assistance, identifying and securing additional treatment services and mutual aid (e.g., community resources for meeting basic needs) and supporting the Member in their efforts to build their capacity to move between and among these services and supports as needed;
   b. Acting as a wellness liaison and supporting the Member in preparing for or accompanying the Member to meetings with, for example, probation officers, social workers, medical and behavioral health appointments, and child protection/child welfare workers;

c. Using transportation as an opportunity to advance the peer relationship by providing temporary assistance with transportation (when available through the provider organization) to essential self-help, peer support, and medical and behavioral health appointments;
d. Transitioning to community-based transportation resources by providing support and mentorship and/or supporting the Member's independence in obtaining transportation resources, including support in accessing transportation services through MassHealth;
e. Delivering services on a mobile basis to the Member in any community-based or outpatient setting that is safe for the Members. Examples of such a setting include a diversionary unit, a day program, a self-help meeting, an emergency department, home, workplace, other community-based locations (e.g., the library, park, etc.), or remotely; and
f. The CPS may provide temporary assistance with transportation to essential self-help, peer support, and medical and behavioral health appointments while transitioning to community-based transportation resources.

4. When working with pregnant and/or parenting Members, in addition to the requirements listed above, the CPS must:
   a. Use a peer mentoring framework, work collaboratively with the pregnant and/or parenting Member to create and coordinate Plan of Safe Care (also called Family Support Plan) specifically designed to help the Member identify needed services for wellness and parenting;
   b. Support the Member around perinatal health and support needs, housing needs, healthcare needs, income needs, and mental health and substance use disorder treatment needs (including Medication for Addiction Treatment (MAT), as identified in the Plan of Safe Care);
   c. Become familiar with local resources, such as home visiting services, lactation support services, parenting support groups, childcare programs, and other services designed to support parents and/or parents in recovery. Develop partnerships with local service providers, including local DCF and Early Intervention staff to facilitate engagement and self-advocacy on part of the Member; and
   d. Help the Member understand the DCF custody assessment process and support the Member in advocating for custody as appropriate. Assist the Member in following through on a Plan of Safe Care, or a DCF Family Action Plan, if they have an open case.

5. CPS is billed as a daily case rate. In order to receive the case rate for CPS services, the CBHC/CMHC must document and be able to demonstrate that the CPS has completed each of the following minimum activities with any Member on their caseload:
   a. A Member is considered to be on the CPS's caseload if the CPS has had at least one documented contact with the Member within the past seven days. Contact means at least one of the following examples of interaction between the Member and the CPS have occurred:
      i. An electronic or remote communication (text, email, phone, or audio-visual communication) during which the Member demonstrates engagement through reciprocating texts, emails, or engaging in phone or audio-visual communications;
      ii. An in-person meeting; or

iii. The CPS accompanying the Member to an appointment (such as medical or behavioral health, court, education, housing, employment, etc.). Visits may be in person or via telehealth.
iv. These ongoing connections must support peer relationship and support the Member in working towards the goals in the wellness plan.

b. At least one in-person meeting at the onset of service delivery, within one week of referral, to develop initial goals with the Member (this might include a wellness plan, as appropriate); and
c. Sufficient time spent on case-related work without the Member present, but aimed at further assisting the Member in accomplishing goals (e.g., phone calls to providers, identifying materials/supports, etc.) is expected throughout the course of engagement, included within the daily case rate, and should be documented accordingly in the Member's record. These activities are intended to support the work with the Member but not replace actual connections between the CPS and the Member.

Staffing Requirements

1. CPSs must be able to safely and effectively provide behavioral health recovery support to others. They must be willing and able to share their path to recovery and their lived experience of recovery with Members.
2. CPSs must have successfully participated in trainings and/or coursework that is designed to prepare individuals to serve as CPSs. The training program must be approved by EOHHS.
3. CPSs must receive direct supervision from an independently licensed clinician or a Certified Peer Supervisor.
4. CPSs must have obtained or must be able to demonstrate that they are actively working to obtain credentialing as a Certified Peer Specialist.
5. The CPS is employed by a larger organization that provides behavioral health services and is licensed within the Commonwealth of Massachusetts.

Service Community, and Collateral Linkages

1. The provider employing the CPS maintains written affiliation agreements, which may include Qualified Service Organization Agreements (QSOA), Memorandum of Understanding (MOU), Business Associates Agreements (BAA) or linkage agreements, with local behavioral health providers that refer a high volume of Members to its program and/or to which the program refers a high volume of Members. Such agreements include the referral process, as well as transition, aftercare, and discharge processes. Affiliation agreements should exist with a wide variety of organizations, including behavioral health, medical, and non-medical service settings including:
   a. Behavioral health services
      i. Non-24-hour behavioral health treatment
      ii. Intensive Outpatient Programs
      iii. Licensed Mental Health Centers
      iv. Community Behavioral Health Centers
      v. Partial Hospitalization Programs
      vi. Structured Outpatient Addiction Programs (SOAPs)

vii. Opioid Treatment Programs (OTPs)
viii. Office-Based Addiction and Opioid Treatment (OBAT/OBOT) programs
ix. Adult Mobile Crisis Intervention (AMCI)
x. 24-hour behavioral health treatment
xi. Inpatient Psychiatric Treatment
xii. Acute Treatment Services (ATS/ASAM Level 3.7)
xiii. Clinical Stabilization Services (CSS/ASAM Level 3.5)
xiv. Community Crisis Stabilization (CCS)
xv. Residential Rehabilitation Services (RRS/ASAM Level 3.1)

b. Medical Settings
   i. Emergency departments
   ii. Primary care practices
   iii. Hospital settings
   iv. OB/GYN practices
   v. Community Health Centers
c. Other Settings
d. Adult Community Clinical Services (ACCS)
e. Criminal justice programs
f. Specialty drug courts
g. Faith-based organizations
h. Recovery support centers
i. Supportive/sober housing

Quality Management (QM)

1. The facility and/or program will develop and maintain a quality management plan that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is used and will include outcome measures and satisfaction surveys to measure and improve the quality of care and service delivered to Members.
3. Clinical outcomes data must be made available upon request and must be consistent with performance standards for this service.
4. All reportable adverse incidents will be reported to Molina Healthcare within one business day of their occurrence per DMH/DPH licensing requirements. A reportable adverse incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who has recently been discharged from services.
5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

Process Specifications

Assessment, Treatment, and Documentation

1. The CPS must document any activities related to supporting a Member, including face-to-face, telephonic, and collateral contacts.
2. The Member defines and directs the structure and content of their own wellness and recovery. A wellness plan may be a structure that is used to support the Member in their wellness and recovery. Goals and the plan for the Member's journey in recovery are made in a collaborative and supportive manner with the CPS. With the Member's consent, a copy of the wellness plan is part of the Member's record. Wellness plans do not need to follow a standard template but must meet the individual needs of the Member, incorporate goals, and provide sustainability planning for discharge.