THE UNIVERSITY OF TEXAS AT AUSTIN
SCHOOL OF SOCIAL WORK
CENTER FOR SOCIAL WORK RESEARCH

Peer-Provided Services and Medicaid Billing at the Local Mental Health Authorities in Texas

September 2011

Laura Kaufman, M.A.
Wendy Brooks, M.A.
Stacey Stevens-Manser, Ph.D.

Texas Institute of Excellence in Mental Health
The Center for Social Work Research
University of Texas at Austin
1717 West 6th Street, Suite 335
Austin, Texas 78703
Phone: (512) 232-0600
Fax: (512)232-0617
http://blogs.utexas.edu/mental-health-institute/

Suggested citation: Kaufman, L., Brooks, W., & Stevens-Manser, S. (2011). Peer-provided services and Medicaid billing at the local mental health authorities in Texas. Texas Institute for Excellence in Mental Health, Center for Social Work Research, University of Texas at Austin.

Funding for this report was made possible (in part) by the Mental Health Transformation State Incentive Grant (MHT-SIG Grant Number: 5 U79 SM57485-05) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderator do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices or organizations imply endorsement by the US Government.

EXECUTIVE SUMMARY

Introduction

In 2003, the President's New Freedom Commission on Mental Health proposed a transformed mental health system that is both consumer-centered and recovery oriented (New Freedom Commission on Mental Health, 2003). To this end, Texas was one of seven (and eventually nine) states to be awarded a Mental Health Transformation – State Incentive Grant. To transform the mental health system in Texas, Via Hope was created to provide training and technical assistance for consumers, family members, and mental health providers.

The primary initiative of Via Hope was to develop a Peer Specialist Training and Certification Program. The first training class commenced in March 2010 and six classes have occurred as of October 2011. Certified Peer Specialists are not employed in a variety of settings across the state, including Local Mental Health Authorities (LMHAs), state hospitals, Consumer Operated Service Providers, among others (Brooks, Kaufman, Stevens-Manser, 2011). In order to generate revenue, some organizations bill Medicaid for reimbursement of peer-provided services. The intent of this evaluation was to gain an understanding of the extent to which LMHAs are utilizing peer specialists and billing for the services provided by this workforce. For organizations not employing peer specialists and/or not utilizing the Medicaid billing codes, researchers sought to examine the factors that hinder the provider from doing so.

Design & Methods

DSHS contracted with researchers from the University of Texas at Austin – Center for Social Work Research (UT-CSWR) to administer a survey to examine peer-provided services within LMHAs, the utilization of Medicaid codes for PSs, and perceived barriers and benefits associated with utilizing and hiring PSs. An online survey was disseminated via email to 37 of the 38 LMHAs in the state of Texas. All respondents completed the survey (at least partially), resulting in a 100% response rate.

Survey Findings

Peer specialists are highly utilized within LMHAs in Texas. The 25 organizations currently employing this workforce, reported utilizing between 1 and 14 PSs each. Of the 83 total PSs employed, most positions are part-time (71.1%), while the remaining are full-time (25.3%), vacant (1.2%), or unspecified (2.4%). Providers pay PSs an average hourly pay of $10.57, which is equal to an annual salary of $21, 986 for a full-time employee and $10,993 for a part-time employee. Nearly all (96%) of the organizations employing PSs exceed monthly supervision requirement set forth by the TAC.

According to the TAC, peer-provided services can be billed for under Medication Training and Support, Skills Training, and Psychosocial Rehabilitation. Medication Training and Support was indicated as being the least utilized billing code and provided service, while Psychosocial

Rehabilitation seems to be billed for and provided most often. Barriers experienced related to Medicaid billing include lack of appropriate supervisors, issues with training and credentialing, documentation difficulties, lack of employed PSs, and confusion surrounding the billing codes. Non-billable services include general support, outreach and engagement, and training/education.

LMHAs report utilizing nearly twice as many peer volunteers compared to paid PSs, using between 145 and 147 volunteers. Services provided most frequently by peer volunteers include providing peer support to clients and serving on various committees or councils. All but one LMHA indicated potential exists for peer volunteers to transition to paid staff.

Peer specialists are perceived as highly beneficial for providers and consumers alike. For providers, PSs promote recovery oriented practices within the organization, broaden the array of services, and serve as agents that aid in the eradication of stigma. On the other hand, they connect with consumers on a deep level, instill hope that recovery is possible, enhance engagement with treatment and services, strengthen their support networks, and serve as recovery role models. PSs may also have the ability to affect consumers and providers at the same time by providing insight on a variety of mental health issues and bridging the gap between consumer and provider. Despite all the perceived PS benefit, some barriers continue to exist in utilizing PSs. These barriers most often include identifying and recruiting appropriate individuals, difficulties related to PSs maintaining their personal recovery, lack of financial resources to fund these positions, and credentialing and training issues.
Training and technical assistance (TTA) is one way DSHS could address the barriers experienced by LMHAs in utilizing peers. Most organizations (86.5%) indicated interest in receiving TTA targeting the increased use of PSs. Specifically, organizations expressed an interest in measuring peer service outcomes, educating patients and family members, receiving training in skill building, psychosocial rehabilitation and peer service modality, ideas to improve PS efficiency, the opportunity to participate in initiatives such as the RFLC, assistance in identifying qualified candidates, and expanding peer services. Fewer organizations (52.8%) expressed interested in receiving TTA to assist in the employment of PSs. Areas of interest include identifying and recruiting potential candidates, enhancing PS supervision, an increase in the frequency with and location of the PSTC classes offered, generation of funding and the Medicaid billing process, increasing staff acceptance, reducing stigma, enhancing PS computer skills, developing a better understanding of the social security system, best practices in handing PS workloads and stress associated with job roles, and creating a solid peer volunteer program.

Many centers (23 of 37) do not feel like their capacity to provide peer support services meets the demand, indicating a tremendous need for organizations to enhance their peer-provided services. To keep up with demand, LMHAs cite utilizing the following strategies: hiring additional peer specialists; obtaining executive level buy-in for peer-provided services; identifying additional funding streams; creating a consumer committee to identify and hire additional peers, and introducing additional peer programming.

Recommendations

- Encourage the employment of peer specialists at all LMHAs in the state through the provision of information and resources demonstrating the benefits associated with integrating peer specialists into the organization.
- Prevent burnout and feelings of isolation by hiring more than one PS per organization and encourage employed PSs to offer reciprocal peer support to one another, either informally or in formal peer specialist support meetings.
- Address barriers of identifying and recruiting appropriate candidates by employing creative strategies and conduct interviews with committees of interviews that consists of includes PSs and consumers (Wolf, Lawrence, Ryan & Hoge, 2010). Provide ongoing support to continue resolving these issues and/or others that arise.
- Conduct research of PS supervision to determine optimal frequency (daily, weekly, monthly), type (observations, face-to-face meetings), and position (QMHP, LMHA), revise TAC accordingly, and inform LMHAs of best practices.
- To maximize billing potential, provide organizations with Medicaid training and technical assistance, which may include documentation, identifying services that can be billed for, or clarifying the billing codes and rules. Utilize LMHAs with established programs to demonstrate Medicaid reimbursement process.
- Establish infrastructure that would allow PSs to bill for peer-provided services that are distinct from other "professional" services. Using other states (i.e. Georgia, Wisconsin) as an example; consider applying for a Medicaid waiver.
- Employ PSs at various state agencies and at multiple levels within the mental health system to foster a recovery-oriented system of care while eradicating stigma.
- Provide tailored TTA to address specific needs of LMHAs regarding the utilization and hiring PSs.
- Inform LMHAs of all potential funding options available, particularly those that are not the common forms the revenue (i.e. block grant funding and Medicaid). Consider offering grants or other incentives to enhance the use of PSs.

Conclusions & Discussion

While most LMHAs in the state of Texas utilize mental health consumers as paid peer specialists, many do not bill Medicaid for peer-provided services. In order to maximize the billing potential of mental health organizations, DSHS should address the barriers associated with billing Medicaid and utilizing peer specialists. Training and technical assistance to address the factors that could potentially hinder the system of care from being recovery-oriented and consumer-centered should be tailored to meet the needs of the organization. Lessons learned from this report related to LMHAs could potentially be applied to other types of mental health organizations as a way to fully transform the system.

TABLE OF CONTENTS

List of Figures

List of Tables

INTRODUCTION

As the mental health system transforms to become increasingly consumer-centered and recovery-oriented, states must establish infrastructure to ensure integral services and technology are incorporated into the system of care (New Freedom Commission on Mental Health, 2003). In Texas, the Mental Health and Substance Abuse Division (MHSA) within the Department of State Health Services (DSHS) created a vision of "Hope, Resilience, and Recovery for Everyone" in the state (Texas DSHS, 2011). Peer specialists are individuals with lived experience of mental health issues who have initiated their recovery journey and are willing to use their life experiences to assist others in earlier stages of the recovery process (Davidson, Chinman, Sells, & Rowe, 2006; Hebert, Drebing, Rosenheck, Young, & Armstrong, 2008). This workforce can help the MHSA Division realize its vision by serving as recovery role models, altering negative attitudes to eradicate stigma, and enhancing the support networks of consumers. While peer services yield a number of benefits in promoting recovery and hope, peer providers may also positively impact the mental health system by delivering cost-effective services demonstrated to reduce the frequency and duration of psychiatric hospitalizations and expand the service array of the traditional mental health system (Solomon, 2004).

> Peer specialists can help realize the vision of "Hope, Resilience, and Recovery for Everyone."

In 2009, Via Hope, Texas Mental Health Resource was created as a collaborative effort between DSHS, Mental Health American of Texas (MHAT), and National Alliance on Mental Illness (NAMI). Via Hope serves as a training and technical assistance resource for youth and adult mental health consumers, family members, and mental health providers. To fulfill its primary initiative, Via Hope developed a statewide Peer Specialist Training and Certification (PSTC) program. The training program takes place over a 5-day period and teaches participants the skills and knowledge necessary to facilitate recovery and wellness in the consumers they serve through didactic instruction, discussion and role-play. After the training program, individuals are invited to participate in a certification exam, successful completion of which results in becoming a *certified* peer specialist (CPS). While the state successfully established infrastructure to train and certify peer specialists, the long-term financial viability of this workforce remains unknown.

Peer specialists are employed by a number of mental health facilities, including community clinics, state hospitals, and consumer-run organizations, among others. Peer support remains a critical component of a recovery-oriented model of care and funding must be generated to compensate and support peer specialists. Texas, like most states, primarily relies on Medicaid to fund mental health services (New Freedom Commission on Mental Health, 2003). In order for peer provided services to qualify for Medicaid reimbursement, states must set forth supervision and training requirements and the services must be part of a comprehensive plan to promote individualized goals (U.S. Centers for Medicare and Medicaid Services [CMS], 2007).

DESIGN & METHODS

DSHS contracted with researchers at the Center for Social Work Research at the University of Texas at Austin (UT-CSWR) to examine the utilization of both peer specialists and of Medicaid billing codes as they relate to peer-provided services. UT-CSWR developed a survey with feedback from staff at DSHS and Via Hope, the intent of which was to gain a better understanding of:

1. Services provided by peers within the LMHA centers;
2. If and how LMHAs bill Medicaid for peer provided services; and,
3. What hinders or facilitates LMHA centers hiring peers to provide services.

Based on contact information provided by DSHS, researchers sent an email to Adult Mental Health Directors at 37 LMHAs, copying the Executive Director. The email included an explanation of the purpose of the survey and how findings will be used, a link to the survey, and contact information of the researchers in the event that any questions or problems should arise. Upon clicking the link to the survey, respondents were redirected to SurveyMonkey, a web-based survey application system. The introductory page included the same explanation of purpose given in the email, definitions of peer specialists and certified family partners, directions to complete the survey, as well as researcher contact information. A copy of the introductory page can be found in Appendix A. The survey administration period was two weeks, with reminder emails sent out one week after the initial email and the morning of the final day of survey administration.

Participating Organizations

The state of Texas is divided into 38 Local Mental Health Authority (LMHA) service areas, which have been designated to serve as the governing bodies for the local service areas' community mental health clinics. Each clinic is responsible for providing services aimed toward improving the lives of mental health consumers in the state (Texas DSHS, 2011). Figure 1 below presents of map of the 38 LMHA service areas in the state of Texas.

The survey was distributed to 37 of the LMHAs, all of which responded to the survey. North Texas Behavioral Health Authority (NTBHA, service area 30 in Figure 1), is unique in that it oversees providers that are part of a Medicaid managed care plan called NorthSTAR. NTBHA was not included in this survey as this system operated very differently than the other LMHAs.

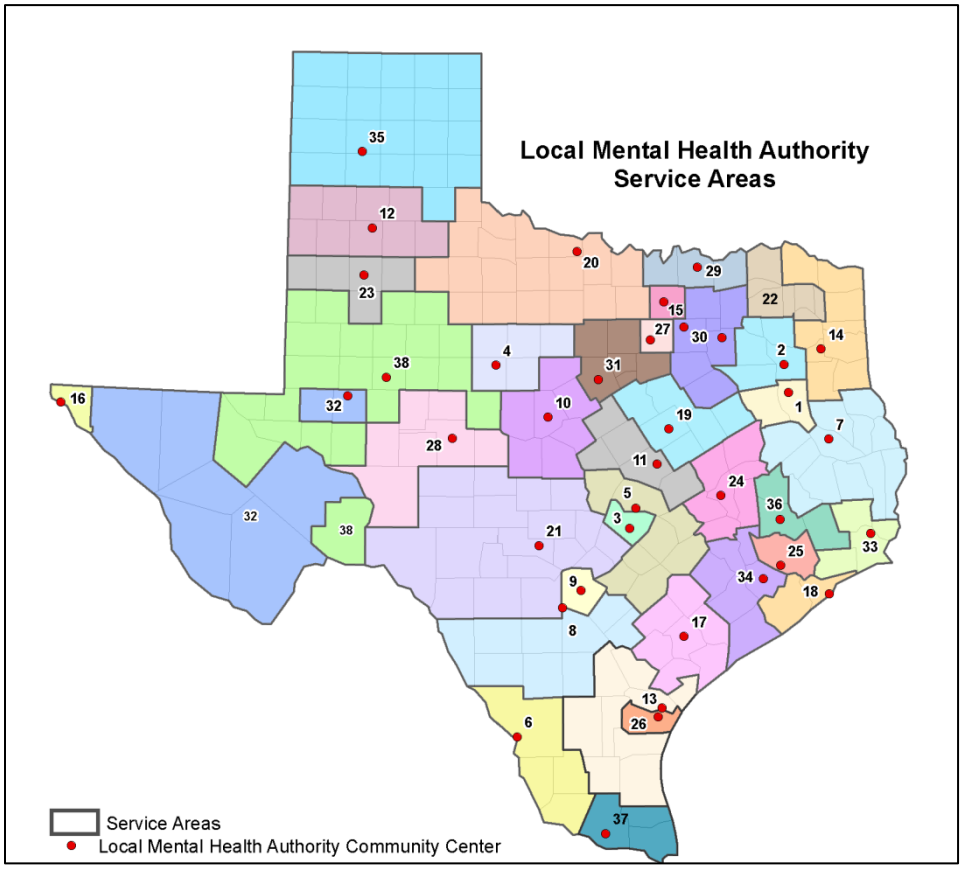

Figure 1: Map of LMHA service areas. Source: (DSHS, 2007)

ID	LMHA	ID	LMHA
1	Anderson/Cherokee Community Enrichment Services	20	Helen Farabee Regional MHMR Centers
2	Andrews Center	21	Hill Country Community MHMR Center
3	Austin Travis County Integral Care	22	Lakes Regional MHMR Center
4	Betty Hardwick Center	23	Lubbock Regional MHMR Center
5	Bluebonnet Trails Community MHRMR Center	24	MHMR Authority of Brazos Valley
6	Border Region MHMR Community Center	25	MHMR Authority of Harris County
7	Burke Center	27	MHMR of Tarrant County
8	Camino Real Community MHMR Center	28	MHMR Services for the Concho Valley
9	Center for Healthcare Services	29	MHMR Services of Texoma
10	Center for Life Resources	30*	North Texas Behavioral Health Authority
11	Central Counties Center for MHMR Services	31	Pecan Valley MHMR Region
12	Central Plains Center	32	Permian Basin Community Centers
13	Coastal Plains Community MHMR Center	33	Spindletop MHMR Services
14	Community HealthCore	34	Texana MHMR Center
15	Denton County MHMR Center	35	Texas Panhandle MHMR
16	El Paso MHMR	36	Tri-County MHMR Services
17	Gulf Bend MHMR Center	37	Tropical Texas Center for MHMR
18	Gulf Coast Center	38	West Texas Centers for MHMR
19	Heart of Texas Region MHMR Center		

* NTBHA not included in this survey

SURVEY FINDINGS[1]

Employment and Utilization of Peer Specialists

Of the 37 LMHAs, 25 (67.6%) employed peer specialists (PSs) at the time of the survey, while the remaining 12 (32.4%) organizations did not. The fact that LMHA employs PSs does not necessarily mean that these individuals have been certified. Respondents were instructed to select the "no" answer choice if the LMHA utilized peers as volunteers only. As illustrated on the map below (Figure 2), regions in which the number of LMHAs employing PSs is relatively high are the South, Central, North-Central, and East regions of Texas. All Via Hope Peer Specialist training classes occurred in Austin, Dallas, or Houston, which may explain, in addition to the rural nature of some of the other regions, why the distribution of centers employing PSs are largely clustered around these areas.

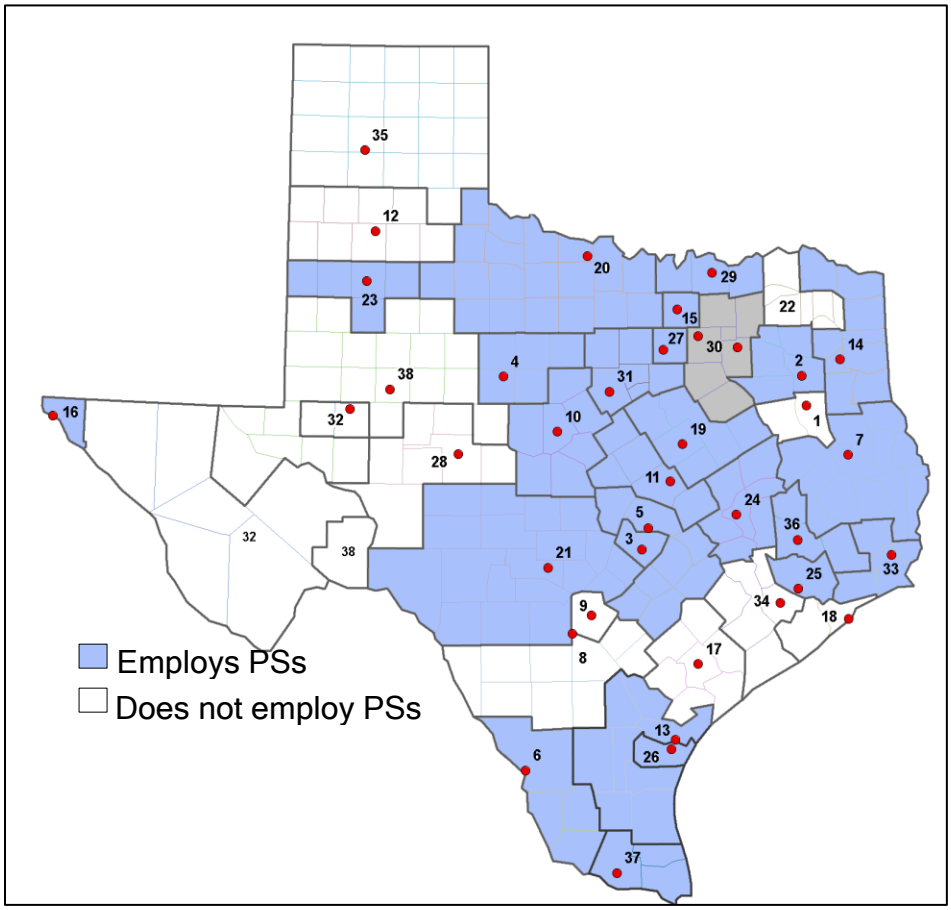

Figure 2: LMHAs employing PSs in Texas. Source: (DSHS, 2007)

Of the 12 organizations not employing PSs, 10 provided explanations as to why the LMHA does not utilize PSs as paid employees. The most frequently identified reason was difficulty in identifying and recruiting appropriate candidates for the position. This concern was expressed throughout the survey, even amongst organizations that employed PSs at the time of the survey. To address this issue, Wolf and colleagues

[1] A summary of survey responses is attached in Appendix B.

(2010) suggest using innovative strategies to recruit PS candidates, such as contacting support groups, advocacy organizations and consumer operated service providers (COSPs) to aid in identifying potential peer specialists in addition to utilizing word of mouth and online communities (e.g., Craigslist, Facebook) to advertise for open positions. Conducting well-structured interviews with a committee of interviewers that includes PSs and consumers will ensure that the best candidate is selected for the position (Wolf, Lawrence, Ryan & Hoge, 2010). Upon hiring, candidates should receive orientation and training and should have clearly-defined job descriptions to avoid role confusion and conflict (Gates & Akabas, 2007; Wolf et al., 2010). Other concerns hindering LMHAs from employing PSs, which can be resolved using the aforementioned approaches, include attendance and transportation issues and the potential for one's personal recovery to regress. Two organizations also expressed the lack of an accessible training and certification program, highlighting the need for Via Hope to continue marketing the PSTC program across the state and providing training in diverse locations. An additional two organizations explain that while the LMHA does not employ PSs, they contract with a COSP to provide peer support services (for a more details regarding COSPs, please refer to page 27 of this report). At three organizations, the use of PSs has simply not been further examined or options are being explored to develop this type of position.

> Organizations should employ creative techniques to recruit and identify the best qualified individuals for peer specialist positions.

Number of Peer Specialists Utilized

Organizations employing PSs were asked a number of follow-up questions related to the utilization of PSs. The 25 LMHAs utilizing paid PSs indicated employing between 1 and 14 PSs with a total of 83 PSs currently employed by LMHAs in the state of Texas. Slightly more than one-third of the organizations employ only 1 PS. Working as the only PS at an organization may result in feelings of isolation and/or place a tremendous amount of responsibility on the PS as he/she is likely the sole provider of peer services in the organization (Independent Living Research Utilization [ILRU] Community Living Partnership, 2008). Hiring additional PSs can enhance opportunities for networking and support, prevent burnout and foster long-term job tenure (ILRU, 2008). Figure 3 presents a graph summarizing the number of organizations employing a given number of PSs.

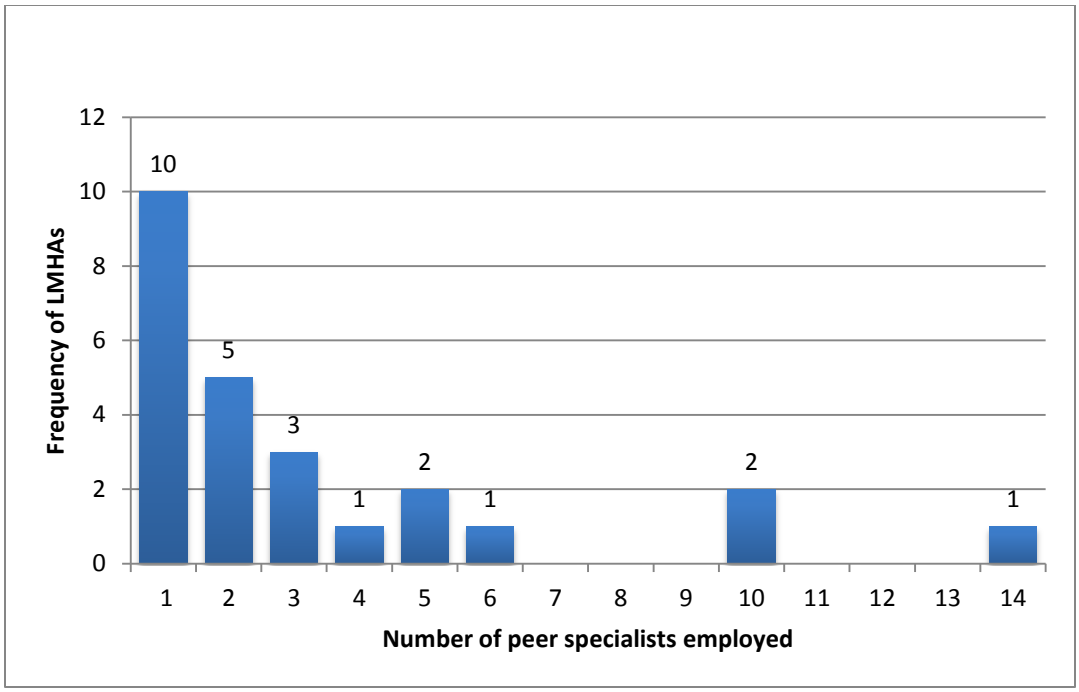

Figure 3: How many peer specialists total are employed by the LMHA?

Employment Status

Of the 83 total PSs employed at the LMHAs, 21 are full-time employees and 59 are part-time employees. One organization reported one part-time position as being vacant and one respondent did not specify full-time or part-time status for the two PS positions at that organization. Figure 4 below depicts the proportion of full-time PSs compared to part-time PSs.

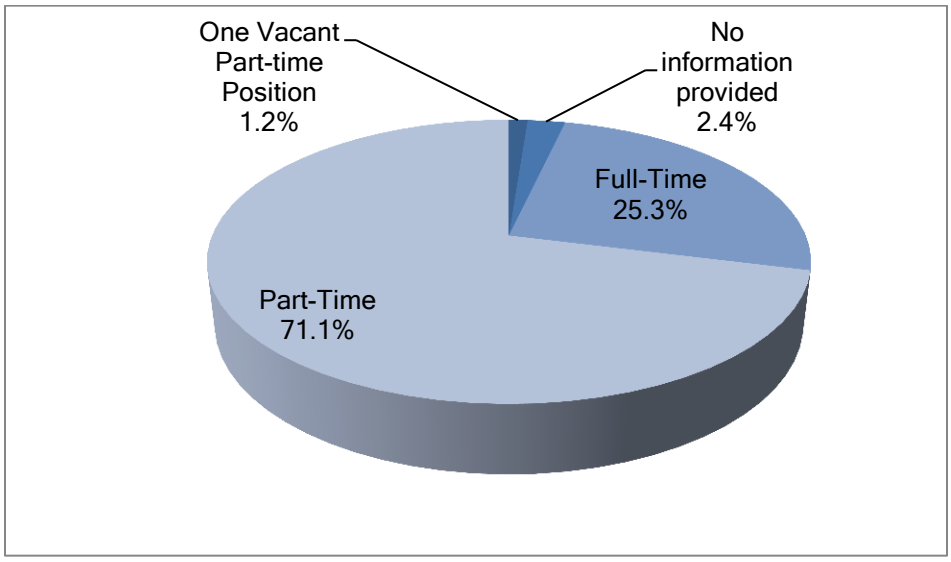

Figure 4: Employment status.

Satellite Clinics Utilizing Peer Specialists

In order to gain an understanding of the concentration of PSs within a given LMHA service area, organizations were asked the total number of satellite clinics within the service area and the number of satellite clinics employing PSs. Many of the organizations report employing PSs, while reporting none of their satellite clinics employ PSs. From this, the researchers inferred that those reporting satellite clinics did not employ PSs meant that only the main clinic employed PSs. Following that assumption, 52 of the 114 (45.6%) total satellite clinics employ PSs.

Peer Specialist Pay

The overall range of hourly wages of PSs employed by the LMHAs is between $7.25 (federal minimum wage) and $15.48, with the average pay being approximately $10.57 per hour of work. For a part-time peer specialist working 20 hours a week, annual salary ranges between $7,540 and $16,099, with an average annual salary of $10,993. For a full-time peer specialist working 40 hours a week, annual salary ranges between $15,080 and $32,198, with an average salary of $21,986. Exactly half of the organizations with paid PSs offer hourly wages in the $9.00 to $10.99 range. Figure 5 depicts the pay of PSs by organization.

The average hourly pay for a peer specialist in Texas is $10.57, the equivalent of an annual salary of $21,986 for a full-time employee and $10,993 for a part-time employee.

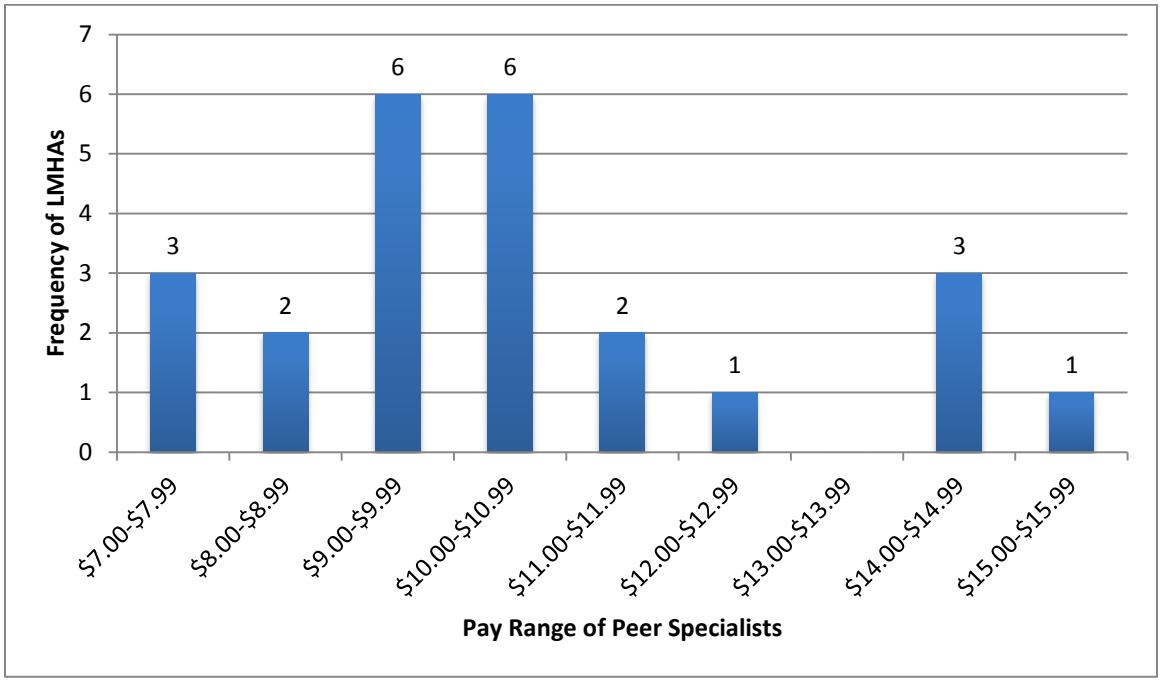

Figure 5: LMHAs grouped by hourly wage range offered to PSs.

Via Hope Peer Specialist Training and Certification Program

Organizations employing PSs were asked how many of their PSs have attended the Via Hope Peer Specialist Training. Twenty-three of the 25 respondents (92%) affirmed knowing the number of PS staff that attended this training. The number of trained PSs at each organization ranges from 0 to 10, with the overall total being 51 trained. Four organizations reported that none of their PSs have attended the training, although one of these organizations stated that they had two PSs planning to attend the training but that their acceptance was cancelled by Via Hope (reason for cancellation was not provided by respondent). Slightly more than one-third of the LMHAs (9) employ one PS who has attended the training. Three organizations report two employed PSs have attended the training; four organizations have three PSs who have attended; two LMHAs have sent seven PSs; while one organization currently employs 10 PSs who have attended the Via Hope Peer Specialist Training. Figure 5 below summarizes information regarding PSs who have attended the training.

After attending the Via Hope Peer Specialist Training class, participants are invited to take an examination, successful completion of which (a score of 70 or above) results in certification. Organizations were asked the number of PS staff that have been certified through Via Hope's PSTC program. Twenty-one of the 25 respondents were aware of the number of PSs who have been certified through the program. The number of Certified Peer Specialists (CPSs) employed by the LMHAs ranges from 0 to 7, with the overall total being 33. Seven organizations do not currently employ any PS staff certified through Via Hope's certification program. An additional seven LMHAs employ one CPS, four organizations employ three CPSs, and one organization each employs two, five, and seven CPSs.

Overall, a total of 51 PSs employed at LMHAs have attended the Via Hope PSTC training, 33 of which have successfully completed the certification exam (64.7% passing rate). Based on exam scores provided by Via Hope from PSs trained in calendar year 2010, the passing rate is much higher at 84.5%, indicating that PSs employed at LMHAs may be more likely to pass the certification exam than individuals employed in other settings. An alternate explanation may be that survey respondents are unaware of the certification rates of PS staff, underscoring the importance of PSs to announce their certification status to employers as a way to demonstrate their qualifications. Figure 6 below depicts the percentage of individuals that have attended the training compared to the number certified through the training.

Number of PSs employed at LMHAs: 83
Number of PSs employed at LMHAs trained: 51
Number of PSs employed at LMHAs certified: 33

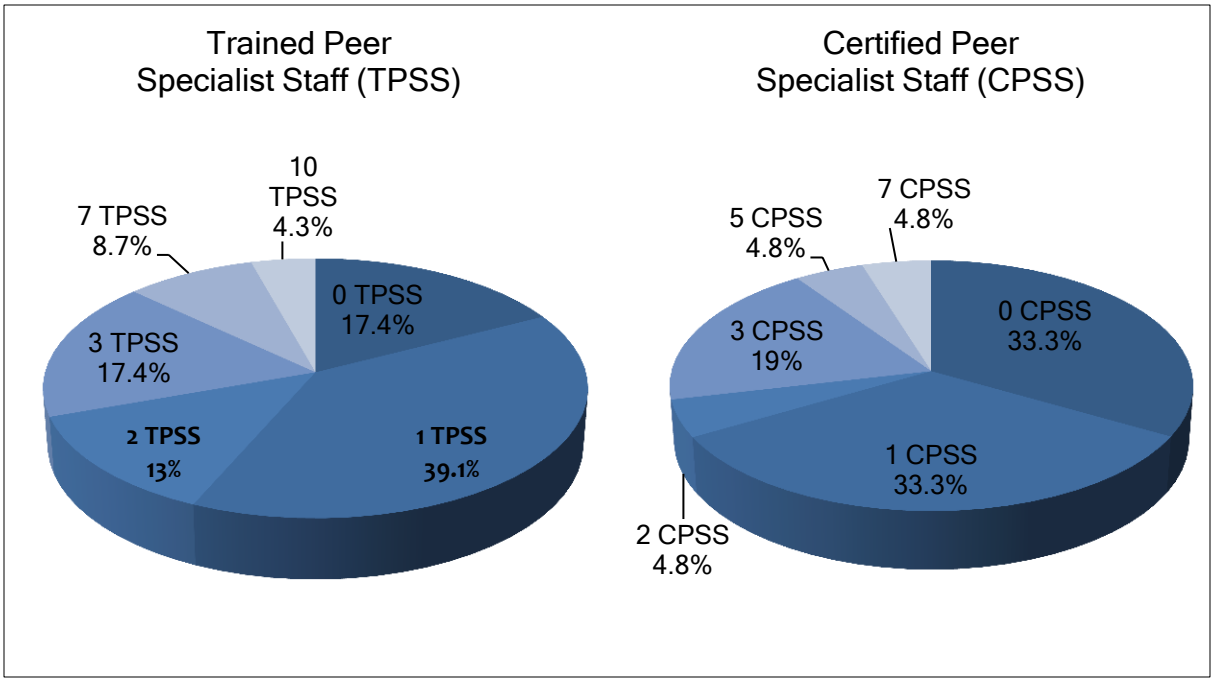

Figure 6: Percentage of trained PS Staff vs. Certified PS Staff.

Nearly all (94.6%) of the LMHAs in Texas are aware of the Via Hope PSTC program. Only one organization[2] reported being unaware of the program and one additional organization did not respond to this question. Though awareness of the program is high, it may not be seen as accessible to all, as indicated by comments provided throughout the survey. Some organizations expressed concerns with the lack of an accessible training and certification program for PSs in the state. While Via Hope may demonstrate success in marketing the PSTC program, the accessibility of the program should be increased by offering the classes more frequently and in a wider variety of geographic locations.

Services Provided by Peer Specialists

PS service provision varies by center. The most frequently reported services provided include group facilitation (11 of 24 responding centers), psychosocial rehabilitation (9), skills training and support (6), individual peer support (6), and education/training activities (6). In a survey of CPSs in the state of Texas, 59.4% of respondents identified leading/facilitating support groups as an area of interest for continuing education (Brooks, Kaufman, & Stevens-Manser, 2011). It appears that group facilitation is an integral part of the PS role, as indicated by both the centers and the PSs themselves. Because the Via Hope Peer Specialist training does not address how to conduct peer support groups or any issues that may

Facilitating support groups has been identified as an integral part of the PS role by both LMHAs and peer specialists.

[2] This organization [Andrews Center] participated in Via Hope's Peer Specialist Learning Community in FY 2010, indicating that other individuals at the organizations are likely aware of the PSTC program but not the survey respondent from this LMHA.

potentially arise when facilitating groups, continuing education classes should be offered that enhance group facilitation skills in peer providers.

Additional services provided are as follows: consumer engagement (4); transportation (3); community outreach (3); family support (3); fitness/wellness activities, including WRAP (3); advocacy (2); peer coaching (2); accessing resources (2); rehabilitative services – general (2); leadership/advisory activities (2); art and other creative activities (2); treatment/recovery planning (2); attending doctor's appointments with consumers (2); TIMA (2); Wraparound services (1); medication training and support (1); producing monthly newsletter (1); managing COSP contracts (1); documentation (1); crisis intervention (1); veteran services (1); and supported employment (1).

The services listed by respondents consist of both Medicaid billable and non-billable services. Services billable to Medicaid are discussed extensively beginning on page 15 of this report, with Table 2 and Figure 9 summarizing the utilization of billing codes. Likewise, non-billable services are described on page 25 and summarized in Figure 10.

Supervision

Although federal guidelines state that supervision must be provided by "a competent mental health professional," (CMS, 2007) the definition of an appropriate supervisor as well as frequency, duration, and scope of supervision must be laid out by the state. In Texas, direct clinical supervision is defined by the Texas Administrative Code (TAC), Rule §419.453 as:

"An LPHA's (a licensed practitioner of the healing arts) interaction with a peer provider to ensure that MH rehabilitative services provided by the peer provider are clinically appropriate and in compliance with this subchapter by:

a) conducting a documented face-to-face meeting with the peer provider at regularly scheduled intervals; and
b) conducting, at least monthly, a documented face-to-face observation of the peer provider providing MH rehabilitative services."

LPHA is further defined under the same rule in the TAC as a physician, licensed professional counselor, a licensed clinical social worker, a psychologist, an advanced practice nurse or a licensed marriage and family therapist. Fifteen of the 25 organizations (60%) employing PSs specifically state that supervision is provided by an LPHA. Other supervisors include Clinic Directors, Program Supervisors or Managers, Peer Managers, ACT Team Leaders, and Rehabilitation Administrators or Supervisors. Two organizations stated work is currently being conducted to establish LPHAs in supervisory positions for PSs.

In recognizing the need to train and certify both peer specialists *and* their supervisors, Via Hope developed a CPS Supervisor Training in order to enhance the understanding of the job roles of a peer specialist within an organization, create a supportive environment for PSs, and ensure that peer-provided services are being delivered effectively. As of September 2011, Via Hope has held two classes, training a total of 48

individuals[3] from 16 LMHAs, five State Hospitals, four providers within NorthSTAR, two advocacy organizations, and one Veteran's Administration Health Care system. Via Hope plans on offering an additional three classes in FY 2012.

In terms of frequency of supervision, 68% of the centers (n = 17) employing PS staff provide weekly supervision to PSs. Five organizations provide PS supervision on a monthly basis, two on a daily basis, and one LMHA respondent reports never providing supervision to PSs. Figure 7 below summarizes the frequency of supervision provided to PSs. According to the TAC, observations must be conducted on a monthly basis, while face-to-face meeting requirements are less strict, but must be conducted at "regularly scheduled interviews." The literature suggests that supervision occur weekly and, if possible, be provided in a group setting as to encourage a degree of peer support between peer staff (Sinclair, 2009). Data reported by the centers indicate that a majority (96%) are in compliance with the TAC with 76% meeting the literature's recommendation for supervision and exceeding TAC requirements.

A majority of the organizations (76%) provide PS supervision on at least a weekly basis, meeting the literature's recommendation of weekly supervision.

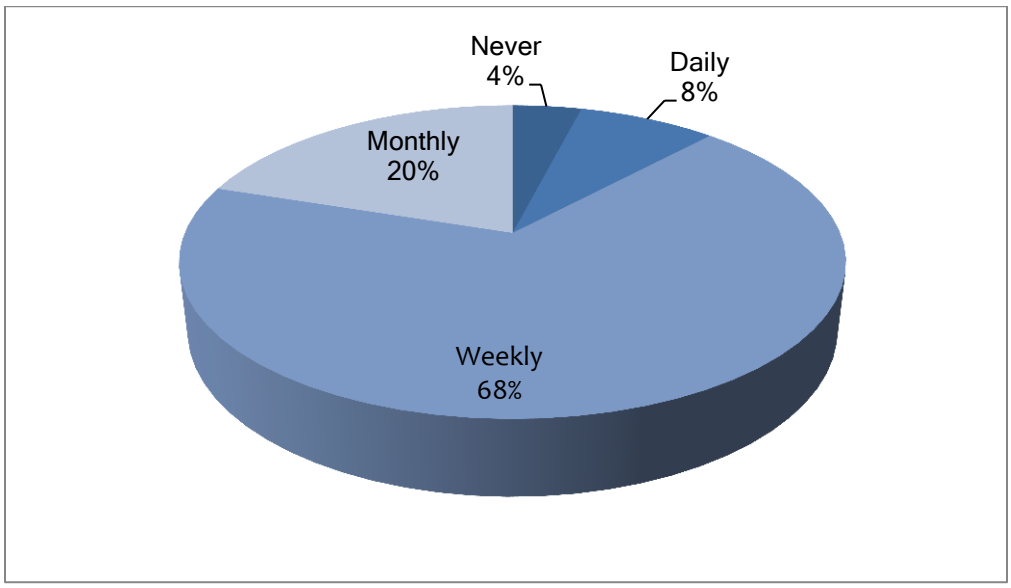

Figure 7: Frequency of supervision.

Training Requirements

In addition to supervision requirements, states must also specify care-coordination and training criteria in order to qualify for Medicaid funding of peer provided services. According to the TAC (Title 25, Part 1, Chapter 419, Subchapter L, Rule §419.464), all staff members providing mental health rehabilitative services must receive training in the following competency areas:

[3] Four of the 48 individuals attending Via Hope's Supervisor training were peer specialists.

(a) “the requirements of this subchapter and of Chapter 412, Subchapter G of this title (relating to the Mental Health Community Services Standards);
(b) the nature of severe and persistent mental illness and serious emotional disturbances;
(c) the dignity and rights of an individual in accordance with Chapter 404, Subchapter E of this title (relating to Rights of Persons Receiving Mental Health Services);
(d) identifying, preventing, and reporting abuse, neglect, and exploitation in accordance with Chapter 414, Subchapter L of this title (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers);
(e) interacting with an individual who has a special physical need such as a hearing or visual impairment;
(f) responding to an individual's language and cultural needs through knowledge of customs, beliefs, and values of various, racial, ethnic, religious, and social groups;
(g) the uniform assessment;
(h) the utilization management guidelines;
(i) developing and implementing an individualized treatment plan;
(j) identifying an individual in crisis;
(k) appropriate actions to take in managing a crisis;
(l) skills training techniques;
(m) the treatment of co-occurring psychiatric and substance use disorders as described in Chapter 411, Subchapter N of this title (relating to Standards for Services to Individuals with Co-Occurring Psychiatric and Substance Use Disorders (COPSD));
(n) the availability of resources within the local community; and
(o) strategies for effectively advocating for an individual.”

When asked to list any training required of PSs, 11 of the of the 25 (44%) LMHAs provided a response specifying that PSs are required to complete the same training as any other staff member employed by the organization. By holding PSs to the same standards of responsibility as any other staff member, organizations enhance the credibility of the PS role. Three organizations require PSs to receive training through Via Hope’s PSTC program and maintain their PS certification. Other required training not included on the list presented above includes: Wellness Recovery Action Planning (WRAP); quarterly training relevant to position; documentation; wraparound training; workplace safety; staff development, and computer training.

By requiring peer specialists to obtain the same training as all other paid staff, organizations are strengthening the legitimacy of the peer specialist workforce.

Utilization of Peer Volunteers

Peer providers are frequently utilized as volunteers in mental health organizations. Of the 37 respondents, 19 (51.4%) organizations utilize consumers as volunteers, while 17 (45.9%) do not. One respondent did not complete this question. When examining the employment of PSs and the utilization of peer volunteers, a majority (86.1%) utilize peers in some capacity, either as paid employees or volunteers; one-third of the

organizations both employ peer specialists *and* utilize peer volunteers. Only five organizations do not utilize peers in any fashion. Table 1 below compares the utilization of peers as volunteers vs. paid staff.

Table 1: Employment of PSs vs. utilization of peer volunteers.

	Employs PSs*	Does Not Employ PSs
Utilizes Consumer Volunteers	12 (33.3% of total)	7 (19.4% of total)
Does Not Utilize Consumer Volunteers	12 (33.3% of total)	5 (13.9% of total)

*One LMHA employs PSs, but did not respond to the question regarding the utilization of consumer volunteers.

Reasons for not utilizing consumer volunteers include lack of consumer interest, all peer workers being paid, utilizing consumer volunteers of other organizations (i.e., drop-in centers, COSPs, and NAMI), minimal utilization limited to clerical activities and/or lack of staff to serve as supervisor of volunteers. Two organizations expressed an interest in developing a consumer volunteer program. Organizations employing PSs but not utilizing peer volunteers should consider creating a position in which a PS serves as a supervisor of the volunteers.

Number of Peer Volunteers Utilized

All 19 organizations utilizing consumers as volunteers provided information regarding the number of consumer volunteers. Overall, there are approximately 145 to 147 (two organizations provided a range of peer volunteers) consumer volunteers within the LMHAs. Responses ranged from 0 to 30. Slightly less than half (8 of 19) of the organizations utilize between 1 and 5 consumer volunteers. The utilization of consumer volunteers by center is depicted in Figure 8 below.

Number of consumer volunteers utilized by LMHAs: 145 to 147
Number of peer specialists employed by LMHAs: 83

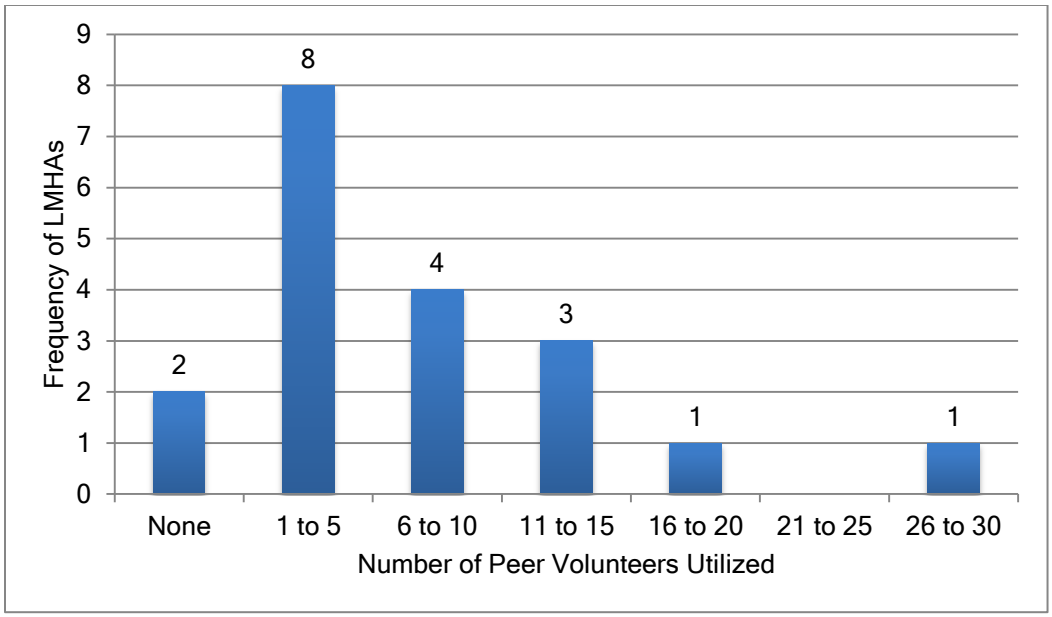

Figure 8: The number of peer volunteers utilized by frequency of LMHAs.

Services Provided by Peer Volunteers

In terms of how consumer volunteers are utilized, the two most frequently reported activities include providing peer support to clients and serving on various committees or councils with 9 and 8 centers respectively reporting volunteers participating in these activities. Other ways in which consumer volunteers are utilized include administrative or clerical work, providing feedback on services, planning social events, advocacy, serving as support staff, and operating a drop-in center. One organization reported activities vary depending on experience and interests of the consumer volunteer.

Career Ladder

Respondents were also asked if there was potential at the organization for consumer volunteers to transition to paid PS staff. Only 1 of the 18 organizations responding to this question indicated no potential for volunteers to become paid staff. Another respondent indicated the possibility of establishing a career ladder if PS staff positions are created. Four organizations confirmed there is the possibility to move upward within the organization, but did not further describe this potential to transition. Other organizations expressed the potential to climb the career ladder as being dependent on the potential candidates interests and abilities (n=7), the amount of funding (n=3), completion of training requirements (n=2), or on PS position vacancies (n=3). Two respondents also noted several peer volunteers as transitioning into paid PS positions in the past.

Medicaid Billing

Organizations may currently bill Medicaid for three peer-provided services: Medication Training and Support, Skills Training, and Psychosocial Rehabilitation. Table 2 and Figure 9 below summarize the relationship between these three services in terms of provision and billing. Medication Training and Support appears to be the least frequently offered by peer providers and billed for by organizations, while Psychosocial Rehabilitation is the most frequently offered and billed. Potential explanations of billing patterns are provided in subsections below, but it is clear that there is potential for more billing using these codes based on the services that LMHAs indicated their PSs provided.

Table 2: Provision of services and use of Medicaid billing codes.

	Not offered or billed	Offered, not billed	Offered *and* billed
Medication Training and Support	67.6%	8.1%	16.2%
Skills Training	45.9%	18.9%	27.0%
Psychosocial Rehabilitation	35.1%	18.9%	37.8%

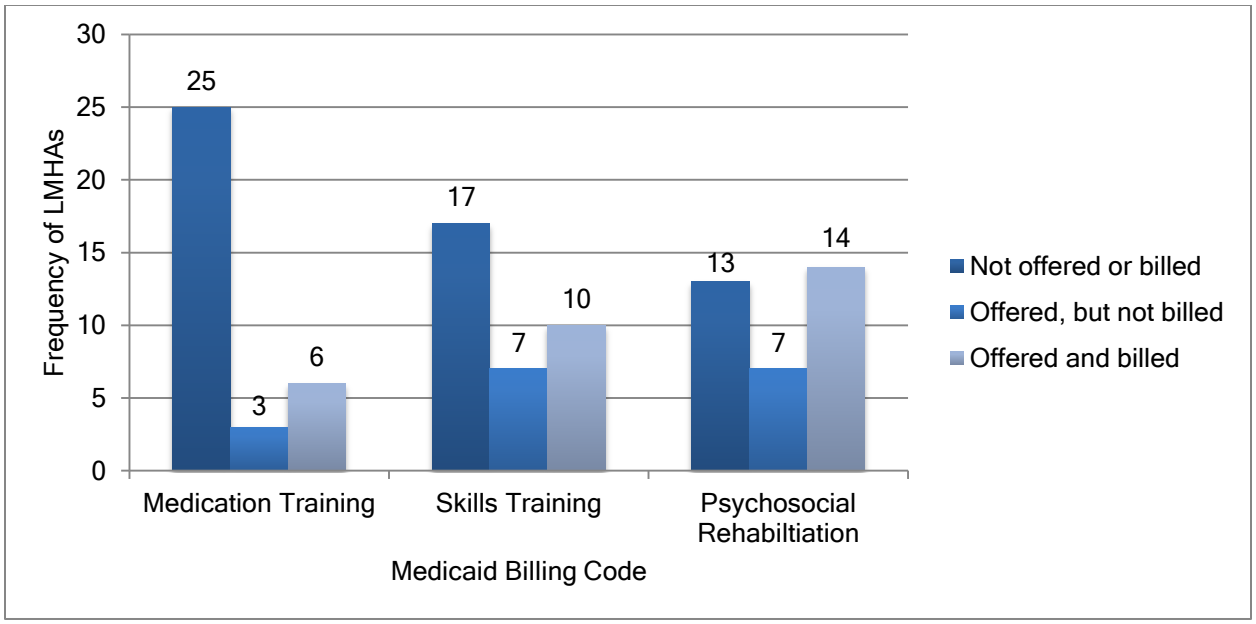

Figure 9: Provision of services and use of Medicaid billing codes.

Medication Training

According to the TAC (Title 25, Part 1, Chapter 419, Subchapter L, Rule §419.458), Medication Training and Support:

> "consist of instruction and guidance based on curricula promulgated by the department. The curricula include the Patient/Family Education Program Guidelines referenced in §419.468(3) of this title (relating to Guidelines), and other materials

which have been formally reviewed and approved by the department to assist an individual in:

(1) Understanding the nature of an adult's severe and persistent mental illness or a child or adolescent's serious emotional disturbance;
(2) Understanding the role of the individual's prescribed medications in reducing symptoms and increasing or maintaining the individual's functioning;
(3) Identifying and managing the individual's symptoms and potential side-effects of the individual's medication;
(4) Learning the contraindications of the individual's medication;
(5) Understanding the overdose precautions of the individual's medication; and
(6) Learning self-administration of the individual's medication."

Although none of these areas are addressed by the Via Hope PSTC curriculum, peer providers can be reimbursed through Medicaid for providing medication training and support services to eligible adults in Texas. Responses on the survey indicate that only six organizations bill Medicaid for peer provided medication training and support. Of the 28 organizations that do not bill for medication training, PSs at 25 organizations do not offer this service, while PSs at three organizations offer the service but their employment organizations do not bill. Three organizations did not respond to this question.

Common reasons why PSs do not offer Medication Training and Support to consumers include not employing any PS staff, utilizing other staff to provide medication training and support services, or PSs provide services other than medication training. Other explanations provided by one organization each include: billing using the QMHP code rather than the code of Peer Provided Medication Training and Support; lack of training necessary to provide these services; PS serve in a volunteer capacity and are therefore not reimbursed for services provided; lack of appropriate supervisor necessary to bill; and working on setting up billing codes for PSs at their organization.

When asked why the LMHA does not bill Medicaid for peer provided medication training and support even though the service is provided by PSs, respondents noted credentialing issues and groups not meeting requirements necessary to bill Medicaid.

For those organizations affirming that they bill Medicaid for medication training provided by PSs, descriptions of these services include Patient and Family Education programs, Texas Implementation of Medication Algorithms (TIMA), and medication training materials sponsored by the employment organization. Four organizations bill medication for individual medication training and support services, while two organizations bill for both individual *and* group medication training and support services. Table 3 below summarizes explanations related to the provision of peer-provided Medication Training and Support services and the utilization of this Medicaid billing code.

Table 3: Summary of responses related to medication training and support.

Offered and billed (17.6% of responding LMHAS)	Offered, but not billed (8.8% of responding LMHAS)	Not offered or billed (73.5% of responding LMHAS)
Services offered: • Patient and Family Education programs • Texas Implementation of Medication Algorithms (TIMA) • Presentation of medication training materials developed by organization	Explanations: • Credentialing issues • Not meeting group requirements	Explanations: • No PS staff currently employed • Other staff provide these services • PSs utilized in other capacities • Billing using QMHP code • Lack of necessary training • PSs serve in a volunteer capacity • Lack of appropriate supervisor • Currently working on setting up peer provider billing codes

To determine the number of clients served and the associated number of client hours, researchers obtained data from DSHS related to encounters between providers and clients at each center. While Medication Training and Support provided in a group setting increased from FY2010 to FY2011, the same service provided in an individual format decreased. This data is presented in Table 4 below. When examining the data by LMHA, the DSHS data did not correspond to the survey responses in all instances. Contact was attempted with all the organizations regarding discrepant data. Explanations indicate that centers made a mistake in responding to the survey (*n*=2); miscommunication occurred with the accounting department in billing/coding for peer-provided services (n=2); recent changes in PS service provision resulting in changes in the utilization of billing codes (n=1); and, utilization of QMHP medication training and support code rather than the peer provided code (n=1).

Table 4: Summary of DSHS data related to medication training and support.

		FY2010	FY2011
Individual Medication Training and Support	Client Hours	154.85	62
	Clients Served	106	47
Group Medication Training and Support	Client Hours	1205.65	2039
	Clients Served	834	1057

Because the PS training does not specifically address medication training and support, PSs may not be particularly skilled in providing these services. Often, PSs provide services related to social support and advocacy, rather than "clinical" services such as medication training. Instead, nursing and other medical staff more often provide these types of services. That is not to say that PSs could not competently provide this service, but that their skills may be better utilized providing other services or that additional training would be needed in order for them to offer the medication training and support service.

Skills Training

As defined in the TAC, skills training and development services consist of providing training to an eligible individual *or* teaching an eligible individual specific skills.

Training includes:

(a) "Addresses severe and persistent mental illness or serious emotional disturbance and symptom-related problems that interfere with the individual's functioning and living, working, and learning environment;
(b) provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community; and
(c) facilitates the individual's community integration and increases his or her community tenure."

Skills include:
(a) "skills for managing daily responsibilities (e.g., paying bills, attending school and performing chores);
(b) communication skills (e.g., effective communication and recognizing or change problematic communication styles);
(c) pro-social skills (e.g., replacing problematic behaviors with behaviors that are socially acceptable);
(d) problem-solving skills;
(e) assertiveness skills (e.g., resisting peer pressure, replacing aggressive behaviors with assertive behaviors, and expressing one's own opinion acceptably);
(f) social skills (e.g., selection of appropriate friends and healthy activities);
(g) stress reduction techniques (e.g., progressive muscle relaxation, deep breathing exercises, guided imagery, and selected visualization);
(h) anger management skills (e.g., identification of antecedents to anger, calming down, stopping and thinking before acting, handling criticism, avoiding and disengaging from explosive situations);
(i) skills to manage the symptoms of mental illness and to recognize and modify unreasonable beliefs, thoughts and expectations;
(j) skills to identify and utilize community resources and informal supports;
(k) skills to identify and utilize acceptable leisure time activities (e.g., identifying pleasurable leisure time activities that will foster acceptable behavior); and
(l) independent living skills (e.g., money management, accessing and using transportation, grocery shopping, maintaining housing, maintaining a job, and decision making)."

Ten of the respondents reported that PSs provide services related to skills training *and* that the LMHA is reimbursed for these services through Medicaid. An additional seven respondents reported that although PSs offer this service, the center does not receive Medicaid funding for skills training. PSs at 17 centers do not offer skills training to consumers and are thus not reimbursed through Medicaid. Table 5 below summarizes explanations related to the peer-provided skills training billing code.

Table 5: Summary of responses related to the skills training.

Offered and billed (29.4% of responding LMHAS)	Offered, but not billed (20.6% of responding LMHAS)	Not offered or billed (50% of responding LMHAS)

Services offered:
• skills for managing daily responsibilities
• communication skills
• problem-solving skills
• social skills
• stress reduction techniques
• skills to manage the symptoms of mental illness and to recognize and modify unreasonable beliefs, thoughts and expectations
• skills to identify and utilize community resources and informal supports
• skills to identify and utilize acceptable leisure time activities
• independent living skills
  • recovery skills
  • coping skills
	Explanations:
	• Peers utilized in other capacities
	• Peers offer services primarily to SP3 clients, whom do not generally receive skills training
	• PS is volunteer, not paid employee
	• Lack of appropriate credentials
		Explanations:
		• Issues related to credentialing, supervision, or group requirements
		• In process of setting up billing
		• Skills training typically offered by licensed professionals
		• Billed under Rehabilitation Option, rather than Peer Provided Skills Training (PSs are QMHPs)

LMHAs in which peer provided skills training services are offered and billed for were asked to describe the skills training provided by PSs. All of the skills listed above (TAC) were provided by PSs with the exception of pro-social, assertiveness, and anger management skills. Centers also cited that PSs offer recovery skills and coping skills training to consumers. Skills to manage symptoms of mental illness were the most frequently reported training provided by PSs, with four LMHAs citing that these services are provided and billed for, followed by independent living skills (n=3), social skills (n=2), and skills for managing daily responsibilities (n=2). All other areas within this code were currently provided by one center each. Two organizations bill Medicaid for Individual Peer Provided Skills Training only, one organization bills for Group Skills Training only, while most (n=7) organizations bill for both Individual and Group Skills Training.

Reasons reported for PSs not offering skills training to eligible consumers include (a) no PSs employed at the organization, (b) peer utilized in capacities other than providing skills training, (c) peers are used primarily with individuals in the service package 3 population of which skills training is not generally provided, (d) PS is a volunteer, and (e) lack of appropriate credentials.

For PSs offering skills training services at employing agencies that do not seek Medicaid reimbursement for these services, explanations include (a) issues related to credentialing, supervision, and group requirements; (b) in the process of becoming a billing organization; (c) the services are offered more frequently by licensed professionals; or (d) that peer provided skills training is billed for under the Rehabilitation Option of Medicaid as PSs are QMHPs.

All of the skills listed above are addressed by the Via Hope PSTC curriculum, making PSs trained through this program particularly qualified to provide skills training to eligible adults. Table 6 summarizes the relationship between the TAC skill set areas and PSTC modules.

Table 6: Relationship between TAC skills training and PSTC modules.

Skill Set Area	Training Module	Description of Training Module
Skills for managing daily responsibilities	22: Creating the Life One Wants	Discusses the difficulty of sustaining change in one's life and shares basic steps for accomplishing goals
Communication skills	9: Dynamics of Change	Explains the how and why people change and why change is so difficult to sustain.
	10: Facilitating Recovery Dialogues	Presents guidelines and procedures for facilitating Recovery Dialogues that can be used in mental health programs.
	11: Effective Listening and the Art of Asking Questions, Part 1	Demonstrates effective listening and the art of asking questions and the kinds of questions that are helpful and not helpful in putting a person in touch with his or her own inner wisdom.
	16 & 17: Effective Listening and the Art of Asking Questions, Parts 2&3	Examines the sessions on Dissatisfaction as an Avenue for Change, Facing One's Fears, Combating Negative Self-talk, and Problem Solving in order to identify the kinds of questions that are most helpful.
Pro-social skills	9: Dynamics of Change	Explains the how and why people change and why change is so difficult to sustain.
	10: Facilitating Recovery Dialogues	Presents guidelines and procedures for facilitating Recovery Dialogues that can be used in mental health programs.
	14: Combating Negative Self-Talk	Explores a variety of ways to catch, check and change negative self-talk in order to prevent the spiral into frustration, depression and/or despair.
Problem-solving skills	15: Problem solving with individuals	Shares a problem solving process that can be very helpful in finding solutions to many problems.
Assertiveness skills	7: Creating Program Environments that Promote Recovery	Explains how negative messages keep people from moving forward with their lives, and what it means to surround people with the possibility of recovery.
Social skills	Person-centered planning for Peer Support Whole Health, Part 2	The following lifestyle areas are reviewed: stress management, service to others, and social network.
Stress reduction techniques	Person-centered planning for Peer Support Whole Health, Part 2	The following lifestyle areas are reviewed: stress management, service to others, and social network.
Anger management skills	19, 20, 21: Power, Conflict, and Integrity in the Workplace	Explores a variety of potential areas of conflict in the workplace, presents some of the basic techniques of mediation and conflict resolution and offers an opportunity to practice these in group role-play and small group settings.

Skill Set Area	Training Module	Description of Training Module
	15: Problem solving with individuals	Shares a problem solving process that can be very helpful in finding solutions to many problems.
Skills to manage the symptoms of mental illness and to recognize and modify unreasonable beliefs, thoughts, and expectations	10: Facilitating Recovery Dialogues	Presents guidelines and procedures for facilitating Recovery Dialogues that can be used in mental health programs.
	12: Dissatisfaction as an avenue for change	Shares a process of asking questions that help people reflect on their lives and make their own decisions about what they want to work on in their lives.
	14: Combating Negative Self-Talk	Explores a variety of ways to catch, check and change negative self-talk in order to prevent the spiral into frustration, depression and/or despair.
Skills to identify and utilize community resources and informal supports	22: Creating the Life One Wants	Discusses the difficulty of sustaining change in one's life and shares basic steps for accomplishing goals
Skills to identify and utilize acceptable leisure time activities	Person-centered planning for Peer Support Whole Health, Part 1	The following lifestyle areas are reviewed: healthy eating, physical activity, and restful sleep.
Independent living skills	22: Creating the Life One Wants	Discusses the difficulty of sustaining change in one's life and shares basic steps for accomplishing goals

When examining DSHS encounter data, the number of clients served by and the number of client hours dedicated to Peer Provided Skills Training increased significantly from FY2010 to FY2011, indicating a potential increase in the capacity of peer specialists to provide skills training as a result of Via Hope PSTC program. Table 7 summarizes the DSHS encounter data for Peer Provided Skills Training.

Similar to the Medication Training and Support Billing code, the DSHS data did not correspond to the survey responses in all instances for Skills Training. Explanations indicate that centers made a mistake in responding to the survey (n=2) or that groups were not meeting requirements for billing (n=1). Contact was attempted but not made with an additional six organizations with discrepant data.

Table 7: Summary of DSHS data related to skills training.

		FY2010	FY2011
Individual Skills Training	Client Hours	112.01	277
	Clients Served	33	45
Group Skills Training	Client Hours	312.25	1497
	Clients Served	44	98

Psychosocial Rehabilitation

Psychosocial Rehabilitation Services, as defined in the TAC are:
"are social, educational, vocational, behavioral, and cognitive interventions provided by members of an individual's therapeutic team that address deficits in the individual's ability to develop and maintain social relationships, occupational or educational achievement, and independent living skills that are the result of a severe and persistent mental illness in adults. Psychosocial rehabilitative services may also address the impact of co-occurring disorders upon the individual's ability to reduce symptomology and increase daily functioning. Psychosocial rehabilitative services consist of the following component services:

(a) independent living services;
(b) coordination services;
(c) employment related services;
(d) housing related services;
(e) medication related services; and
(f) crisis related services.

Psychosocial rehabilitation is the most frequently used code to bill Medicaid for services provided by PSs in the state of Texas, with 14 LMHAs billing Medicaid for these services. PSs employed by an additional seven organizations provide psychosocial rehabilitation services, but the LMHA does not seek reimbursement for these services through Medicaid. Thirteen LMHAs do not bill Medicaid, nor do their PSs provide these

services. Table 8 below summarizes explanations related to the peer-provided psychosocial rehabilitation billing code.

For those organizations in which PSs offer Psychosocial Rehabilitation services *and* these services are billed for, the most commonly described service listed by 5 of the 13 (38.5%) organizations billing for psychosocial rehabilitation was independent living skills. The provision of coordination services was noted by 4 of the 13 (30.8%) LMHAs. Employment and housing related services are offered by two organizations, while medication related services are offered by one LMHA. The only component service listed above not offered by any organizations was crisis related services. According to TAC rules, medication training may only be provided by licensed medical personnel, while crisis related services must be provided by a QMHP-CS. Other responses include "general psychosocial rehab", "group services", and "Psych Rehab for A3 and A4 per UM Guidelines and TAC definitions." Four organizations bill for individual Peer Provided Psychosocial Rehabilitation only, while the remaining 10 organizations bill for both group and individual psychosocial rehabilitation services.

At organizations in which PSs offer Psychosocial Rehabilitation Services, but services are not billed for, explanations include: (a) billing as QMHP's; (b) credentialing issues; (c) not meeting group requirements; and (d) LPHA supervision requirements.

Reasons PSs do not offer Psychosocial Rehabilitation Services include (a) not employing PSs; (b) peers employed as volunteers; (c) PSs serving in advisory capacities; (d) position is currently being developed; or (e) utilizing other staff members to provide these services.

Table 8: Summary of Responses related to psychosocial rehabilitation.

Offered and billed (41.2% of responding LMHAS)	Offered, but not billed (20.6% of responding LMHAS)	Not offered or billed (38.2% of responding LMHAS)
Services offered: • Independent living services • Coordination services • Employment related services • Housing related services • Medication related services • "General psychosocial rehabilitation" • "Psychosocial rehabilitation for A3 and A4 UM Guidelines and TAC definitions"	Explanations: • Bill as QMHPs • Credentialing issues • Not meeting group requirements • LPHA supervision requirements	Explanations: • Not employing PSs • Peers work only in volunteer capacity • PSs serve in advisory capacities only • PS positions currently being created • Skills training typically offered by other staff

The Via Hope PSTC curriculum addresses two of the above listed services encompassed by Peer Provided Psychosocial Rehabilitation. These two areas include

independent living services and coordination services, which as noted above, are the two most commonly offered component services. Table 9 below summarizes the association between the peer specialist training curriculum and psychosocial rehabilitation.

Table 9: Relationship between psychosocial rehabilitation and PSTC modules.

Service Area	Training Module	Description of Training Module
Independent living	Creating the Life One Wants	Discusses the difficulty of sustaining change in one's life and shares basic steps for accomplishing goals
	Person-centered planning for Peer Support Whole Health, Part 1	The following lifestyle areas are reviewed: healthy eating, physical activity, and restful sleep.
	Person-centered planning for Peer Support Whole Health, Part 2	The following lifestyle areas are reviewed: stress management, service to others, and social network.
	Person-centered planning for Peer Support Whole Health, Part 3	This session introduces the SMART process for setting and clarifying a whole health goal.
Coordination	Person-centered planning for Peer Support Whole Health, Part 1	The following lifestyle areas are reviewed: healthy eating, physical activity, and restful sleep.
	Person-centered planning for Peer Support Whole Health, Part 2	The following lifestyle areas are reviewed: stress management, service to others, and social network.
	Person-centered planning for Peer Support Whole Health, Part 3	This session introduces the SMART process for setting and clarifying a whole health goal.
Employment Related	Not addressed by specific module	
Housing Related	Not addressed by specific module	
Medication Related	Not addressed by specific module	
Crisis Related	Not addressed by specific module	

When examining DSHS encounter data, the number of clients served by and the number of client hours dedicated to Individual Peer Provided Skills Training decreased from FY2010 to FY2011, while the number of client hours dedicated to Group Peer Provided Psychosocial Rehabilitation increased from FY2010 to FY2011. The number of clients served by Group Peer Provided Psychosocial Rehabilitation basically remained unchanged in the past year. This indicates that while individual psychosocial rehabilitation has decreased over the past year, clients are attending more psychosocial rehabilitation groups. Again, this trend may be associated with the increased number of PSs and enhanced capacity of PSs to provide these types of services as a result of PSTC program. The increase in client hours of group Psychosocial Rehabilitation also underscores the importance of additional training and education in group facilitation.

Table 10 below summarizes the DSHS encounter data for Peer Provided Psychosocial Rehabilitation.

The DSHS data and survey responses for Psychosocial Rehabilitation did not match up for all centers. When asked to explain the discrepancies between the two data sources, explanations revealed that centers made a mistake in responding to the survey (*n*=4), miscommunication occurred with the accounting department in billing or coding for peer-provided services (*n*=2), or an error in the encounter data as indicated by only one client being served for 15 minutes (*n*=1). Contact was not made with an additional six organizations with discrepant data.

Table 10: Summary of DSHS data related to psychosocial rehabilitation.

		FY2010	FY2011
Individual Psychosocial Rehabilitation	Client Hours	2256.22	1040
	Clients Served	490	201
Group Psychosocial Rehabilitation	Client Hours	1360.31	2525
	Clients Served	260	266

Barriers Related to Medicaid Billing

Results from the survey indicate that while PSs provide services that could be billed for, some centers are not seeking Medicaid reimbursement for these services. While nine organizations indicated that they have not experienced any barriers in billing Medicaid for peer provided services, two organizations said they do not utilize PSs and one utilizes the local COSP to provide peer services, most of the remaining organizations provided descriptions of barriers they may have experienced in billing Medicaid. Five centers stated that there are difficulties related to supervision, as they are currently experiencing a lack of appropriate supervisors within LMHA centers. An additional five respondents noted issues associated with credentialing and training for PSs. Four organizations each cited issues related to documentation requirements or lack of PSs employed due to recruitment difficulties. Three organizations identified lack of clarity around billing codes as being a major barrier. These responses indicate opportunities for DSHS-MHSA to communicate with LMHAs about these misconceptions so LMHAs can increase their billing for services provided by PSs.

To maximize the billing potential of peer-provided services, DSHS-MHSA should consider enhance clarity surrounding Medicaid billing codes, as misconceptions and confusion exist.

Other barriers include lack of appropriate billing codes associated with peer provided services (*n*=2), attendance at groups (*n*=2), the need to change the Anasazi system matrix (*n*=1), lack of PS computer skills (*n*=1), and exclusion of certain service packages (*n*=1). Table 11 below presents a frequency table summarizing the barriers in billing Medicaid for peer provided services.

Table 11: Barriers to Medicaid billing.

Barrier	# of organizations citing
Difficulties with supervision	5
Training and credentialing issues	5
Issues with recruitment/lack of PSs	4
Issues with documentation	3
Lack of clarity around billing codes	3
Other	7
No barriers	9
Lack of appropriate billing codes for PS services	2
Low attendance at groups	2
Need to change Anasazi system matrix	1
Lack of PS computer skills	1
Exclusion of certain service packages	1

Other Services Provided by Peer Specialists

Respondents were asked to describe any additional peer provided services that the LMHA either does not or cannot bill Medicaid for. Four centers did not provide a response to this question, five additional centers said the question was either not applicable or that they do not utilize PSs at their center, and five more stated that there are no additional services provided by PSs in their centers. Of the remaining 23 centers, peer provided services not billed for include support (peer, parent/family, and veteran), outreach/engagement, training/education, transportation, advisory functions, clinical, art groups, social activities, physical activities, spirituality, advocacy, and administrative work. Figure 10 below depicts the extent to which each of these services is provided.

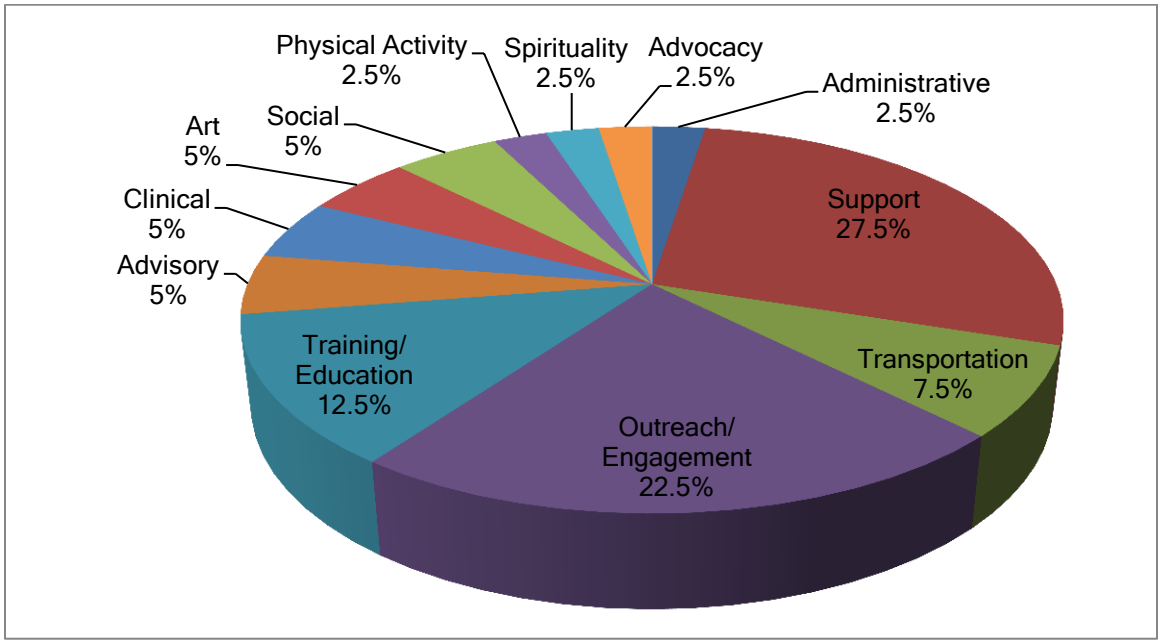

Figure 10: Peer-provided services not billed for.

Currently, LMHAs in Texas may only bill for peer services under the Rehabilitation Option. However, it is apparent that PSs provide unique services that reach beyond the

rehabilitation services of other mental health providers. DSHS should recognize the distinct impact of PSs and their unique ability to relate to consumers based on shared experiences by establishing infrastructure for mental health providers to generate revenue to fund peer-provided services.

Perceived Barriers and Benefits in Utilizing Peer Specialists

Benefits

Organizations were asked to identify the biggest benefits associated with utilizing PSs in the LMHA centers, to which 33 organizations provided a response. Three organizations did not answer this question and one responded that they do not utilize PSs at their organization. The greatest benefit appears to be the connection consumers form with PSs who have similar life experiences. Promoting the recovery model, providing insight on mental health issues to both consumers and staff, instilling a sense of hope in consumers, engaging consumers, broadening the organization's service array, the ability of PSs to serve as a role model, and bridging the gap between the provider and the consumer are all commonly perceived benefits associated with utilized PSs within LMHA centers (Table 12). Other benefits less frequently cited by organizations include the strengthening of the consumer's support system and reduction of stigma.

Table 12: Benefits of utilizing peer specialists.

Benefit	# of organizations citing
Connection with PSs due to similar life experiences	16
Promoting recovery	13
Providing insight for consumers and staff	10
Sense of hope	8
Consumer engagement	7
Broadening service array	6
Role modeling	5
Bridging gap between provider and consumer	5
Strengthening support system	3
Destigmatization	2

Barriers

Centers often experience barriers in utilizing PSs at their organizations (Table 13). The most reported barriers were recruiting and identifying appropriate candidates for the PS position, cited by 12 of the 35 individuals who responded to this question, and difficulty for the PS to maintain one's personal recovery when working under conditions that can oftentimes be stressful, which was noted by 11 organizations. Nine LMHAs also identified a lack of funding as a major barrier to utilizing PSs, while seven organizations noted difficulties associated with credentialing or lack of training opportunities for PSs. Other less frequently cited barriers include the need for a paradigm shift so that staff are more accepting of the peer providers, transportation, supervision requirements, establishing legitimacy of PS position, issues related to dependability and attendance, creating appropriate job descriptions, employing peers in rural areas, lack of office

space, and work limits related to SSI and SSDI. Two organizations did not provide a response to this question, one noted that they have not experienced any barriers related to utilizing PSs, and an additional two respondents stated that they utilize COSPs to provide peer support services. DSHS should consider connecting the LMHAs to training and technical assistance opportunities to address these barriers and maximize the billing potential for peer-provided services.

Table 13: Barriers to utilizing peer specialists.

Barrier	Number of organizations citing
Identifying and recruiting appropriate individuals	12
PSs ability to maintain personal recovery	11
Lack of financial resources	9
Credentialing/training issues	7
Need for paradigm shift	4
Transportation issues	4
Supervision requirements	3
Need to legitimize PS position	2
Dependability and attendance	2
Appropriate job descriptions	2
Rural location	1
Office space	1
Difficulties related to disability benefits	1
No barriers	1

Training and Technical Assistance Needs

Training and Technical Assistance to Increase Use of Peer Specialists

Most organizations (86.5%) indicated interest in receiving training or technical assistance (TTA) designed to increase the use of PSs in their centers. Of the organizations who did not express interest in receiving TTA, two organizations stated they are already receiving this type of assistance and one indicated the only type of TTA they would be interested in would involve wellness groups, documentation, or person-centered planning. At the time of the survey, these three organizations were participating in a collaborative initiative of Via Hope, DSHS, and UT-CSWR called the Recovery-Focused Learning Community (RFLC), a 9-month project intended to

LMHAs requested TTA to increase the use of peer specialists in:

- measuring outcomes of peer services
- educating patients and family members
- skills training
- psychosocial rehabilitation
- PS service modality
- ways to improve PS efficiency
- initiatives similar to the Recovery-Focused Learning Community
- identifying qualified PS candidates
- expanding peer provided services

enhance the recovery orientation of participating organizations. One additional organization not expressing interest in this type of TTA clarifies that the organization utilizes peer services provided by a local COSP.

Twenty-six of the 32 organizations (81.3%) expressing an interest in receiving assistance to increase their use of PSs elaborated on their response. Most respondents expressed openness and willingness to receive any type of training that would help improve their organization but more specifically, organizations requested training in the following areas: measuring outcomes of peer services; Patient and Family Education Program; skills training; rehabilitation; service modality for PSs; ways to improve efficiency; support similar to Via Hope's RFLC initiative ; identifying potential candidates for the position; and how to expand peer provided services.

The few respondents who were more hesitant in receiving TTA stated the training would have to be funded, the Director of Mental Health Services has to approve training programs or that while they welcome training, the center may not currently have the necessary funds to hire PSs. The high level of interest in receiving training and technical assistance indicates that although the PS workforce is relatively new, LMHAs seem ready and willing to learn ways to improve peer support.

Training and Technical Assistance for Employment of Peer Specialists

While LMHAs appeared highly enthusiastic to receiving training to increase their use of PSs, they were not as likely to identify TTA needs to assist in the employment of PSs. Slightly more than half of the organizations (52.8%) identified specific TTA needs, while less than half (47.1%) did not. Specific training areas identified to assist in the employment of PSs included: identifying and recruiting potential candidates; PS supervisor training; more frequent Via Hope peer specialist training that does not require extensive travel; Focus for Life training; USPRA-sponsored peer specialist training; generating funding and the billing process; staff acceptance and destigmatization training; computer skills; the Social Security system; handling PS workloads and stress; and developing a solid peer volunteer program.

LMHAs requested TTA to increase employment of peer specialists in:

- identifying and recruiting potential candidates
- enhancing PS supervision
- offering the Via Hope PS training classes more frequently and in a wider variety of locations
- attending additional peer specialist training
- generating funding and understanding the billing process
- enhancing staff acceptance and reducing stigma
- receiving training to enhance PS computer skills
- understanding the Social Security system
- handling PS workloads and stress
- developing a solid peer volunteer program

Demand for Peer Provided Services

Approximately one-third (12 of 37) of the respondents reported that their LMHA centers capacity to provide peer provided services meets the demand for these services. Slightly more than 62% of centers (23 of 37) do not feel like their capacity meets the demand for these types of services. Two organizations did not provide a response to this question.

For organizations who reported keeping up with the demand for peer support services, 11 respondents offered further explanation. Three of the 12 organizations reported they are currently meeting the demand through a COSP contract, highlighting the significance of these types of organizations to alleviate the overburdened mental health system. An additional three organizations feel that although they are currently maintaining the capacity to provide peer services to all individuals seeking them, they acknowledge the potential for demand to increase. Strategies identified for keeping up with the demand include splitting one PS position into two, gaining buy-in from executive management, identifying funding streams to pay for service, developing a committee of consumers to locate and hire PSs, and gradual introduction of additional programming. One respondent indicated that while they are meeting the demand, the need for PS staff to maintain their personal recovery may sometimes prove difficult due to job stress.

Strategies for meeting the demand for services include:

- Splitting PS position into two
- Obtaining executive level buy-in
- Identifying additional funding streams
- Creating a consumer committee to identify and hire peers
- Introducing additional PS programming

All 23 respondents who indicated the current demand for peer support services surpassed the LMHAs' peer support capacity provided explanations. Ten of these organizations indicated the need to hire additional PSs, but have been unable to as a result of limited funding, and difficulties in retaining PSs. Three organizations specified a goal of employing at least one PS for either the LMHA as a whole or for each individual clinic. However, as discussed previously, caution should be taken in employing one PS, as the organization risks PS burnout. One LMHA acknowledges the use of PSs in expanding services and engaging consumers while another simply states "*Since we started using a peer provider, we have only seen the unlimited potential for their services*." One organization is currently looking at ways to expand their services beyond the service provision at the COSPs they contract with. Other explanations provided include the need to expand peer support services to other satellite clinics; making more referrals than peer provider is able to see; need to better understand Medicaid billing; the center has not assessed the demand for peer support

"Since we started using a peer provider, we have only seen the unlimited potential for their services."

-survey respondent when asked about their organizations' capacity to meet demand for peer support services

services. Again, some organizations do not currently employ PSs and therefore, are not able to keep up with the demand.

Consumer Operated Service Providers (COSPs)

Consumer operated service providers (COSPs) are independent organizations that provide peer support and other non-clinical services to consumers in the public mental health system. In Texas, seven DSHS-funded COSPs currently exist. These organizations receive funding through a sub-contract with local LMHAs. However, additional COSPs have been established through other funding mechanisms. Respondents were asked if their organization contracts with COSPs for the provision of peer-provided services and eight responded affirmatively. Six of the eight were respondents from LMHAs who subcontract with COSPs using DSHS funding that is dedicated to consumer operated services. One organization [MHMR of Tarrant County] indicated they did not contract with a COSP, when in fact they do have a subcontract, explaining that their in-house peer support program primarily provides peer support services at satellite clinics. One of the DSHS-funded COSPs has expanded their program to contract peer support services in other areas in the state and are therefore provided services at an LMHA other than the one they contract with through DSHS. This situation accounts for one of the respondents indicated they contract with a COSP. The remaining organization contracts with the local NAMI chapter for peer support services.

Of the 28 LMHAs indicating that they do not currently contract with a COSP, 25 organizations provide an explanation of why they do not. The three most frequently provided responses included: 1) the LMHA provides peer support services internally (*n*=8), 2) COSPs are not located in geographic proximity (*n*=7), and 3) lack of COSP awareness (*n*=6). One organization requested additional information related to COSPs, one explained that they have not yet explored the option of contracting or the availability of these types of organizations, while other responses include “not yet” and “not needed at this time.”

LMHAs do not contract with COSPs because:

- Peer services are provided internally only
- COSPs are not located in geographic proximity relative to the LMHAs
- LMHAs are unaware of COSP existence

Because LMHAs are generally satisfied with the services provided by contracted COSPs (Kaufman, Stevens-Manser, Espinosa, & Brooks, 2011), the state could consider providing the necessary resources to expand these types of organizations more broadly across Texas. Furthermore, the lack of awareness surrounding COSPs indicates the need for these types of organizations to market themselves and the services they provide to other mental health organizations. This is particularly relevant given the fact that several organizations indicated they do not contract with COSPs due to geographic location but are actually located relatively close to the DSHS-funded COSPs. Also, other COSPs not funded by DSHS (i.e., Mexia Peer Support Center) are established within LMHA service areas and can therefore be contracted to provide peer services to local organizations.

In fact, when asked if LMHAs would contract with COSPs to provide PS services if they were more widely available throughout the state, 78.8% (n=26) of the respondents completing the question indicated that they would. When asked to elaborate, many (38.5%; n=10) said they would consider contracting depending on the cost and/or consumer benefits resulting from COSP services. Some expressed that contracting with a COSP would allow the organization to broaden its service array, while a few requested additional information regarding these organizations. Finally, two organizations stated that they currently contract with COSPs. Reasons respondents offered for not being interested in contracting with COSPs were similar; organizations indicated funding as a barrier in utilizing COSPs and requested more information. Three organizations answered "no" because they prefer to provide PS services internally, and one organization said "maybe."

Additional Comments

When asked if there is anything else they would like DSHS to know about the LMHAs utilization of PSs, 14 organizations did not respond and nine stated they did not have any additional comments. Responses to this question were overwhelmingly positive with many organizations stating the LMHA and/or its consumers have benefitted greatly as a result of peer support services. Others commented that awareness around PSs and peer provided services has increased. Some acknowledged the need for properly trained PSs, while others expressed concerns regarding the funding of these positions. Two reported being satisfied with the services provided by their contracted COSP. Finally, one organization commended the RFLC project as a transformative process, shaping the organization's perspective on recovery.

> "I think it is one of the most important services we have added. In the future, this program will be a catalyst for recovery and consumers will benefit."
>
> *-survey respondent when prompted for final comments*

RECOMMENDATIONS

Employment and Utilization of Peer Specialists

A majority (67.6%) of the LMHAs in Texas currently employ PSs. Although PSs are employed across the state, certain regions seem to utilize PSs more heavily than other regions. LMHAs employing PSs are typically clustered around the regions where the Via Hope PSTC classes occurred. More than one-third of the LMHAs employing PSs have only hired one. Of the 83 total PSs employed at LMHAs in the state of Texas, 51 have been trained and 33 have been certified through Via Hope's PSTC program.

- Recommendation: Offer the training classes in geographic regions across the state of Texas and/or select applications from across the state. Also, because accessibility of a training and certification program was mentioned as a barrier in utilizing peer specialists, consider offering the training program more frequently.
- Recommendation: Encourage organizations not employing PSs to do so by providing information and resources describing the benefits of integrating this workforce into the organization.
- Recommendation: Consider hiring more than one PS per organization to avoid burnout and feelings of isolation.
- Recommendation: To increase the certification rate, Via Hope should consider creating a study guide to prepare trainees for the certification exam and encourage them to consider forming study groups.

The reason most frequently reported as why PSs were not employed was difficulty in identifying and recruiting appropriate candidates for the position.

- Recommendation: Use creative strategies when recruiting individuals for an open PS position, such as through newspaper ads, third party job recruiters, contacting support groups, advocacy groups and consumer-run organizations to identify potential candidates.
- Recommendation: Conduct well-structured interviews with a committee of interviewers that includes PSs and consumers to ensure that the best candidate is selected for the position. Require candidates to attend new employee orientation and training.

The most frequently reported services provided include group facilitation, psychosocial rehabilitation, skills training and support, individual peer support, and education/training activities. PSs identified leading/facilitating support groups as an area of interest for continuing education (Brooks et al., 2011).

- Recommendation: Offer CEU courses that meet the needs of PSs, particularly group facilitation.

PS supervision takes place on a weekly basis at 68% of the centers. According to current rule (Mental Health Rehabilitation Services, Chapter 419, Subchapter L), to bill Medicaid for peer support services, observations must take place monthly and face-to-face meetings must be conducted at regularly scheduled interviews. Some

organizations expressed concerns with the supervision requirements such that the LMHA has experienced difficulties in identifying appropriate LPHAs to supervise PSs.

- Recommendation: Determine the optimal frequency of supervision and inform supervisors of best practices for the management of PSs.
- Recommendation: Consider loosening the supervision requirements to allow bachelor's level QMHPs (including qualified PSs) to supervise PSs. LPHAs may continue to provide indirect supervision through the QMHP.
- Recommendation: Market Via Hope Supervisor's Training more broadly to increase the awareness of the training and enhance the capacity of individuals to effectively supervise PSs.

Utilization of Peer Volunteers

Approximately half of the organizations utilize peers as volunteers and half do not. Overall, there are approximately 146 consumers volunteering at LMHAs. They are most frequently utilized to provide peer support to clients and to serve on committees or councils. Nearly all organizations utilizing peer volunteers indicated that there was potential for these individuals to transition to paid positions as PS staff.

- Recommendation: Encourage organizations to emphasize their career ladder in volunteer recruitment postings and to describe it in new volunteer orientation to build volunteer pools and to improve retention.
- Recommendation: Provide training and technical assistance aimed to assist organizations in developing programs that allow volunteers to transition to paid peer specialist staff.
- Recommendation: Organizations should consider utilizing a peer employee to serve as a supervisor of peer volunteers.

Medicaid Billing

Organizations may currently bill Medicaid for three peer-provided services: Medication Training and Support, Skills Training, and Psychosocial Rehabilitation. Medication Training and Support appears to be the least frequently offered by peer providers and billed for by organizations, while Psychosocial Rehabilitation is the most frequently offered. For all three billable services, there are organizations that employ PSs who provide the service but the LMHA does not seek Medicaid reimbursement. Barriers in billing for Medicaid include:

1) difficulties related to supervision;
2) issues associated with credentialing and training for PSs;
3) documentation requirements or lack of PSs employed due to recruitment;
4) lack of clarity around billing codes;
5) not having a clear understanding of the services that can be billed for;
6) lack of appropriate billing codes associated with peer provided services;
7) low attendance at groups;
8) the need to change the Anasazi system matrix;
9) lack of computer skills; and
10) exclusion of certain service packages.

- Recommendation: Provide organizations with training and technical assistance regarding Medicaid. This may include documentation of services provided, identifying services that can be billed for, or clarification of the billing codes and rules. Utilize organizations with established programs to demonstrate the Medicaid reimbursement process.
- Recommendation: Consider revising TAC rules, including supervision requirements, to address issues organizations may have with billing Medicaid to allow more LMHAs to bill for peer provided services.
- Recommendation: Establish infrastructure to allow providers to bill for currently non-billable peer services. Consider utilizing Medicaid waivers [i.e., 1915(b)(3) or 1915(c)] or offering incentives to increase the use of PSs at LMHAs.

Perceived Barriers and Benefits in Utilizing Peer Specialists

The ability of consumers connect on a deep level with PSs who have similar life experiences appears to be the most frequently perceived benefit of utilizing PSs. Promoting the recovery model, providing insight on mental health issues to both consumers and staff, instilling a sense of hope in consumers, and engaging consumers are all commonly perceived benefits associated with utilized PSs within LMHA centers.

- Recommendation: Market the benefits associated with utilizing PSs at organizations that are not currently employing peers.
- Recommendation: Employ PSs within state agency departments to foster the recovery model and eradicate stigma at multiple levels in the mental health system.

LMHAs also may experience barriers in utilizing PSs at their organizations. Again, the most reported barriers were recruiting and identifying appropriate candidates for the PS position. Many organizations also reported difficulty for PSs to maintain their personal recovery when working under stressful conditions, lack of funding, difficulties associated with credentialing and lack of training opportunities for PSs.

- Recommendation: Assist organizations in developing strategies for identifying and recruiting appropriate individuals for PS positions and provide guidance on the development of job descriptions and PS supervision.
- Recommendation: Develop opportunities such as ongoing training, yearly conferences, regular webinars, etc. that allow PSs to support each other in their professional roles.

Training and Technical Assistance Needs

Most organizations indicated interest surrounding TTA designed to increase the use of PSs in their centers. Organizations requested TTA in the following areas:

1) measuring outcomes of peer services;
2) Patient and Family Education Program;
3) skills training; rehabilitation;
4) service modality for PSs;
5) ways to improve efficiency;
6) support similar to Via Hope's current initiative, the Recovery-Focused Learning Community";
7) identifying potential candidates for the position; and
8) how to expand peer provided services.

- **Recommendation:** Encourage growth of peer support programs at the LMHA level by providing TTA requested by organizations.

While LMHAs appeared highly enthusiastic about receiving training to increase their use of PSs, they were not as likely to identify TTA needs to assist in the employment of PSs.

- **Recommendation:** Provide individualized TTA based on the needs identified by the organization. For instance, if an organization requests assistance in measuring outcomes of peer services, connect them to resources that will assist them to do so.
- **Recommendation:** Respondents expressed positive feedback related to Via Hope's Recovery-Focused Learning Community (RFLC) initiative. Consider providing similar support to LMHAs (and other mental health provider organizations) in the future.[4]

Demand for Peer Provided Services

Over 60% of centers perceive demand for peer provided services as outweighing their service provision capacity. Many recognized the need to hire additional PSs, but have been unable to as a result of limited funding and difficulties in retaining PSs.

- **Recommendation:** Examine current funding options and inform organizations on all potential funding options available.
- **Recommendation:** Consider offering grants to organizations that enhance their PS capacity.

[4] Via Hope is currently in the process of planning a Recovery Institute for FY2012, which will be a continuation and expansion of the FY2011 RFLC. Comments from the current evaluation support the continuation of this initiative.

CONCLUSIONS & DISCUSSION

Most LMHAs in the state of Texas utilize mental health consumers as paid staff or as volunteers and often in both capacities. Peers capitalize on their unique experiences to relate with consumers on a deep level, promote recovery and wellness, and engage consumers in mental health services. Providers employing PSs enhance their organizational recovery orientation, while offering cost-effective services. Because of the numerous benefits PS may potentially have on consumers, providers, and the system of care, infrastructure should be established that allows the PS workforce to be financially stable for years to come.

In Texas, providers rely on Medicaid to generate a significant amount of funding for mental health services. While LMHAs can bill Medicaid under the Rehabilitation Option for peer-provided services (Medication Training and Support, Skills Training, and Psychosocial Rehabilitation), these billing codes do not fund all the services PSs currently provide and currently, these services are primarily provided by other mental health professionals. DSHS should consider expanding the TAC to include additional services that incorporate notions of peer support, outreach and engagement, and education and training. These three areas, in addition to administrative tasks, were most frequently identified as peer services that are not currently billed for. Because revising the TAC is a time intensive task, DSHS may want to consider offering mental health providers incentives for utilizing PSs within their organizations. In addition, strategies could be adapted from other states that have utilized different waivers to fund peer provided services.

In a survey of PSs in Texas, findings indicated that a majority of PSs are employed by LMHAs (Brooks et al., 2011). However, peers experience employment in other settings as well, including state hospitals, COSPs, HIV/STD education and risk reduction programs, and substance abuse programs, among others. While some findings and recommendations in the current study may be applicable to different organizations utilizing PSs, each employment setting exhibits certain nuances and should be handled as separate entities. For instance, COSPs are not currently able to bill Medicaid for peer-provided services so some of the barriers experienced by LMHAs in billing would not be applicable to COSPs. Similarly, state hospitals would likely cite difficulties related to the in-patient, institutional setting. Importantly, while these organizations may experience distinct barriers related to utilizing peer specialists and billing Medicaid for peer support services, the goal regardless of organization is to facilitate recovery in the consumers they serve. Therefore, it is important that the state support the different settings equally in their facilitation of recovery, but tailor the assistance in a way that recognizes the intricacies and unique community of each organization.

REFERENCES

Brooks, W., Kaufman, L., & Stevens-Manser, S. (2011). *Peer Specialist Training and Certification Program Outcomes Evaluation Report: September 2011.* Austin, TX: University of Texas at Austin Center for Social Work Research.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin, 32*(3), 443-450.

DSHS, Center for Health Statistics. (2007). [Map of LMHA Service Areas in Texas, July 2007]. *Local Mental Health Authority Service Areas: July 2007.* Retrieved from http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=9658.

Gates, L.B. & Akabas, S.H. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration and Policy in Mental Health and Mental Health Services Research, 34,* 293-306.

Hebert, M., Rosenheck, R., Drebing, C., Young, A., & Armstrong, M. (2008). Integrating peer support initiatives in a large healthcare organization. *Psychological Services, 5*(3), 216-227.

Independent Living Research Utilization Community Living Partnership. (2008). *Policy Issue #2: Introducing and supporting peer providers in traditional mental health provider networks.* Houston, TX: O'Brien, J., Tiegreen, W.W., & Campbell, J.

Kaufman, L., Stevens-Manser, S., Espinosa, E., & Brooks, W. (2011). Consumer Operated Service Providers and Local Mental Health Authorities: Assessment of Current Models, Training, and Technical Assistance Needs. Austin, TX: University of Texas at Austin Center for Social Work Research.

New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Sinclair, C. (2009). The implementation of a consumer-provider program: The launching of a Peer Health Worker Program at Pathways to Housing, Inc., Washington, DC. (Unpublished Master's thesis). Retrieved from http://www.ucalgary.ca/md/PARHAD/documents/2009_Carole%20Sinclair_The_Implementation_of_a_Cosumer-Provider_Program.pdf.

Solomon, P. (2004). Peer support / peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-402.

Texas Department of State Health Services. (Last updated: 2011). About the Mental Health and Substance Abuse Division. Retrieved from http://www.dshs.state.tx.us/about-mhsa/.

U.S. Centers for Medicare & Medicaid Services. (2007). *State Medicaid Director Letter #07-011.* Retrieved from http://www.cms.gov/SMDL/downloads/SMD081507A.pdf.

Wolf, J., Lawrence, L.H., Ryan, P.M., & Hoge, M.A. (2010). Emerging practices in employment of persons in recovery in the mental health workforce. *American Journal of Psychiatric Rehabilitation, 13*, 189-207