The Role of Certified Peer Specialists in Capitated Managed Care Plans

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List of Abbreviations

Abbreviation	Definition
CBPAR	Community Based Participatory Action Research
CHIP	Children's Health Insurance Program
CITI	Collaborative Institutional Training Initiative
CLPC	Community Living Policy Center
CMFI	Care Model Focus Initiative
CPS	Certified Peer Specialist
DPC	Disability Policy Consortium
HIPPA	Health Insurance Portability and Accountability Act
IRB	Institutional Review Board
LE Experts	Lived Experience Experts
LTSC	Long Term Support Coordinator
MassHealth	Massachusetts Medicaid program
OC	One Care
RAC	Research Advisory Committee
RLC	Recovery Learning Community
SMI	Serious Mental Illness

Executive Summary

This issue brief provides a snapshot of work completed in a qualitative study of One Care (OC)—a Massachusetts program serving people between the ages of 21 and 64 who are known as "dual eligibles." Dual eligibles have both Medicaid, referred to as "MassHealth" in the state, and Medicare. This research had three goals: (1) to learn

about the effectiveness of Certified Peer Specialists (CPSs) from members who have experience working with a CPS; (2) to use project data to develop policy recommendations to improve the implementation of the CPS role in OC; and (3) to elevate the perspectives and voices of people with lived experience of disability, using Community-Based Participatory Action Research (CBPAR) as a model for empowerment.

The brief provides recommendations based on research conducted to better understand the effectiveness of Certified Peer Specialists (CPSs) as an intervention available to enrollees in the Massachusetts OC program. Under the peer recovery model, services are provided by people who are in long-term recovery and are certified to deliver such services. [1] The purpose of the CPS intervention is to advance the principles of recovery and independent-living philosophy in care teams, while providing direct services to OC members with mental-health diagnoses, experiences of trauma, and/or substance misuse. OC is a fully integrated health program for people with Medicaid and Medicare (dual eligibles) between the ages of 21 and 64. Interviews were conducted with 33 OC members, four CPSs, and four representatives from the three OC plans. The latter comprised one representative from Commonwealth Care Alliance, two from Tufts Health Unify, and one from UnitedHealthcare Connected.

The data in this brief comes from interviews conducted by three lived experience (LE) experts. All LE experts completed the Collaborative Institutional Training Initiative (CITI) Program and supplemental training. The LE experts were also provided with training on qualitative interviewing, data analysis, and evaluation by the Disability Policy Consortium (DPC) and Brandeis University staff. The research was conducted according to Brandeis University's Institutional Review Board protocol requirements and overseen by a Research Advisory Committee (RAC) composed of experts in the field of disability research and LE experts from the disability community.

This brief offers recommendations that the Medicaid office of Massachusetts (MassHealth) should: (1) work with the OC Implementation Council and recovery community on establishing a recovery model centered on the principles of the [Care Model Focus Initiative](CMFI); (2) increase the CPS workforce capacity to meet the needs of populations subjected to racism and other discrimination in addition to stigma associated with mental-health diagnoses, while also addressing inequities in

the CPS workforce itself; (3) expand access to CPSs for OC members; (4) increase inclusion of CPSs in care teams and care planning; (5) create trainings for care coordinators on the recovery model of care by CPSs; and (6) establish strategies for increasing equitable access to CPSs whose lived experience includes experience of linguistic bias, racism, sexism, homophobia, transphobia, and other biases.

Background

Disability advocates, particularly those from the recovery community, successfully advocated for the OC model to contain specific language on integrating recovery principles and inclusion of CPSs on care teams. People with both Medicaid and Medicare are three times more likely than Medicare beneficiaries who are not dual-eligible to have a diagnosis of a serious mental illness (SMI).[2,3] Almost one-third of dual eligibles are diagnosed with Serious Mental Illness (SMI), including schizophrenia, bipolar disorder, or major depressive disorder.[4] There is substantial evidence showing that dually eligible persons experience fragmented care and poor health outcomes because of lack of care coordination. For example, a 2021 report from the Medicaid and Children's Health Insurance Program (CHIP) Payment Access Commission found that in 2018 alone, 50% of adults with SMI enrolled in Medicaid reported unmet mental-health treatment needs.[5]

Mental-health professionals are as likely to hold unconscious biases and interpersonal and internalized racism as other people in society. Racism can compound the barriers to care faced by people living with mental-health diagnoses. It is therefore important to name racism as a factor that can exacerbate a person's mental-health status.[6]

Self-stigma is also a serious challenge for people with SMI and is associated with poor health outcomes. Self-stigma results from people taking on common stereotypes about mental illness such as ideas that they are dangerous, incompetent, or personally responsible for their recovery. These stereotypes become internalized, leading to loss of self-esteem and self-efficacy, which can create significant barriers to recovery.[7] Perceived and experienced stigma, including stigma by health providers,

is a predictor of self-stigma and provides clear evidence of the need for interventions to reduce self-stigma.[8]

Research also suggests that racial and ethnic minority groups often report higher levels of public and self-stigma compared to their white counterparts. Cultural aspects of stigma include structural stigma in Latinx and Asian American communities, which are barriers to care due to lack of adequate or appropriate responsiveness to mental-health providers. Persistent racism also disenfranchises Black Americans. Stigma at the family and social levels can be exacerbated by stereotypes of Asian Americans as hard-working or Black Americans as strong and independent. Research also provides evidence that both persons with SMI and nurses hold similar views of how stigma and discrimination act as barriers to person-centered care for persons with mental-health diagnoses.[9]
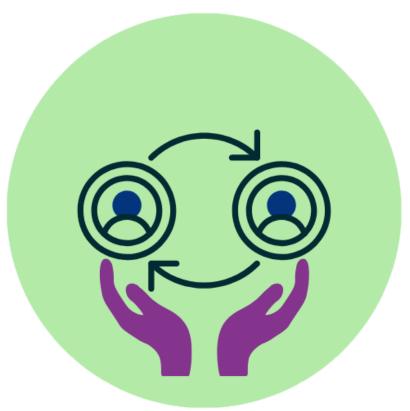
The peer model is defined in terms of interactions and activities that occur between individuals who share similar lived experience of mental-health or substance-use disorders.[10] Under this model, a CPS is an individual who has personally faced challenges related to mental health, trauma, or substance misuse. The CPS receives specialized training to assist others grappling with similar issues. CPSs are certified by the state.[11] They play a key role in care teams by actively addressing stigma and promoting the recovery of individuals with mental-health diagnoses. CPSs are expected to maintain high ethical standards, their own recovery, and professional boundaries.[12] CPSs can instill hope, empower others, and build meaningful connections with individuals on their recovery journeys. CPSs adopt a holistic approach to addressing mental-health issues, emphasizing person-driven activities and individualized support and accompaniment. The unique strength of CPSs lies in their firsthand experience with the recovery process, which gives them credibility among the individuals with whom they work. They also can support self-determination by helping people they serve to establish and achieve recovery goals.[13,14]

Past research indicates that the consumer-CPS bond improves consumers' mental health.[15] Other research shows that CPSs help identify unmet healthcare needs that can lead to negative healthcare outcomes, such as SMI.[16] Other research has stressed that for peer support to be truly effective, particularly for people with disabilities, this support must come in a whole-person-centered approach to care.[17] The current research study builds on past CPS research. It is part of a larger project focused on

strengthening the Independent Living Philosophy and Recovery Model integration into the whole-person approach to OC. OC is a program promoting Medicare and Medicaid services delivered comprehensively as part of a healthcare plan. OC enrollees can choose from three healthcare plans that provide these services.[18]

In 2020, the Disability Policy Consortium (DPC), a disability advocacy and research nonprofit organization based in Boston, Massachusetts, partnered with Brandeis University's Lurie Institute for Disability Policy to research the effectiveness of two interventions in OC. These interventions were the Long-Term Service and Supports Coordinator (LTSC) and CPS initiatives. Both interventions aim to improve members' sense of dignity, agency, and opportunity to live a meaningful life in the community. The LTSC portion of the project was completed in 2022. To read this project's final report on the LTSC portion, click here. This brief discusses findings from the CPS portion of the project. The purpose of the CPS project was to: (1) learn about the effectiveness of CPSs from members who have experience working with a CPS; (2) use project data to develop policy recommendations to improve the implementation of the CPS role in OC; and (3) elevate the perspectives and voices of people with lived experience of disability, using Community-Based Participatory Action Research (CBPAR) as a model for empowerment.

Methodology

The DPC conducted this research in collaboration with the Community Living Policy Center (CLPC), housed within the Lurie Institute for Disability Policy at

Brandeis University, with funding from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR). This research was conducted as part of a larger project focused on strengthening the integration of the Independent Living Philosophy and Recovery Model into the whole-person care approach of OC. The overarching goal of the research project was to examine the effectiveness of the two interventions and to put forward recommendations to advocates and other stakeholders for improving these interventions.

The study was conducted using Community-Based Participatory Action Research (CBPAR) principles. CBPAR is "an approach to research in which researchers and community members share power, resources, and decision-making at all levels of the research process, working together to enhance the understanding of a given phenomenon and integrating that knowledge with action to improve the health and well-being of those most affected."[19] In keeping with the principles of CBPAR, lived experience experts (LE experts) were engaged in all aspects of the project.

Three LE experts conducted semi-structured interviews. The interview guide was developed in collaboration with leadership from the Massachusetts recovery community and the DPC Research Advisory Committee (RAC). The final guide received Brandeis University IRB approval. All OC member interviewees had worked with a CPS, and all other interviewees had direct experience working with OC members or OC policies. The interviews were conducted in two phases. The first phase, where we sought to interview people who received CPS services, occurred during the height of the COVID-19 pandemic (from 2020–2021), and only yielded eight interviews. Thus, we renewed outreach in 2022 and increased the total number of interviews to 41. (The interviewees comprised 33 consumers of CPS services, four individuals employed as CPSs, and four staff members of OC health plans.)

All interviews were conducted via Zoom. All LE experts had lived experience of disability, and were diverse in race, cultural identity, gender identity, and sexual orientation. They received training in fundamentals of CBPAR and broader research principles from DPC staff and Brandeis University staff. All LE experts completed the Collaborative Institutional Training Initiative (CITI) Program and supplemental training. The research was conducted according to Brandeis University's Institutional Review Board protocol requirements and overseen by the

Research Advisory Committee (RAC). The RAC is composed of experts in the field of disability research and LE Experts from the disability community.

The DPC analyzed data from 33 interviews with people who received services from CPSs. Each of the 33 interviewees receiving services from CPSs and each of the four interviewees who worked as CPSs were compensated with a gift card valued at $50. The following sections detail major findings from these interviews and recommendations for improving the CPS program.

Findings from OC member interviews

Members interviewed were a mix of people passively enrolled and actively enrolled in OC. OC members are either passively enrolled into a plan unless they take active steps to disenroll. Active enrollees are people who reached out to MassHealth seeking to enroll in OC. Actively enrolled members mentioned being recommended to OC by a Department of Mental Health (DMH) counselor or a friend. As one interviewee shared, "I got involved through a friend recommendation because I was going through a kind of tough time. I was having … alcohol addiction so I was seeking help. It helped me" (CPS Consumer Interviewee 9).

The degree to which OC care coordinators or other OC care team members were involved in connecting members with a CPS was very unclear. Interviewees did not describe substantive engagement between their CPS, care coordinator, or other care team members. The connection between the CPS and OC did not stand out as part of interviewees' experience.

One interviewee summed up the value of CPSs this way: "[P]eer support is a really cost-effective way of expanding services …. I think that expanding the peer workforce and, also, expanding the contacts that are conducted by each peer worker definitely should pay for itself in terms of reduced need for higher-cost providers" (CPS Consumer Interviewee 7).

Interviewees' relationships with OC plans and with CPSs

Interviewees seem to have positive experiences with OC overall. One person recalled, "the first time I met with an OC person who came out to my home and then, eventually I got other services, including a CPS, after that initial meeting." Another person was grateful to be on OC, stating that "it's been really, really stabilizing being

on OC, not to have to change providers." While these experiences are positive, interviewees did not provide a clear understanding of OC as a person-centered integrated-care model. They also were not always aware of how their plan could help them with all their needs. For example, one interviewee described how a representative from a social service organization "made me aware of the additional benefits, such as having availability of a nurse, and transportation and different benefits …. I realized it would definitely benefit me. I went through the organization [which] helped me go through the paperwork" (CPS Consumer Interviewee 2).

OC members interviewed described their relationship with CPSs as positive. The interviewees viewed the CPS intervention as highly effective. Interviewees described the peer model as the key to the success of the CPS relationship.

Members interviewed expressed highly favorable experiences when collaborating with a CPS. They particularly highlighted the CPS's ability to facilitate connections to services and provide support in dealing with trauma. The peer role is differentiated from that of other care-team members because of the shared experience between the peer and the enrollee. Trust and shared experience stand out as being of paramount importance to interviewees.

Overall, interviewees reported having very positive experiences working with CPSs. They particularly appreciated how these specialists can connect people with services and help them cope with trauma. The fact that CPSs had similar experiences and could thus identify with the people they served was also seen as beneficial in helping motivate and connect them with services. The recognition that shared experience was a better base for understanding than gaining cultural expertise through academic sources, was strongly felt by many interviewees. They cited these strengths as enabling closer relationships, a sense of belonging, and as

being "game-changers" (CPS Consumer Interviewee 6). Other themes described by interviewees included CPSs being good listeners, caring, thoughtful, respectful, trustworthy, and someone in whom they could confide.

The interviewees felt they were loved by their CPSs. They felt their CPSs understood them and offered guidance and counsel beyond what the interviewees expected. Respondents described having good, caring relationships with their CPS, increasing their sense of belonging and connection. As stated by one interviewee about their CPS, "[he] always loves to get to meet people and get to know them. So, he's someone that he really loves everyone ... he knows everyone in my family and house" (CPS Consumer Interviewee 14).

The importance of the shared experience between the member and the CPS in the recovery process cannot be overstated. One interviewee put it this way, "[w]hen the CPS was in my shoes he was able to win. He was able to recover. So, that's part of what's inspiring me" (CPS Consumer Interviewee 29). Another person described the peer as a mentor, "promoting the mind, body in terms of recovery and resiliency" (CPS Consumer Interviewee 32). Finally, another member summarized their relationship with their CPS this way: "[CPSs are] helpful when they share their recovery story [and] ... do activities with people, ... take them places, ... go for walks with them, ... encourage them to get involved in hobbies or activities" (CPS Consumer Interviewee 8).

CPSs were also described as helpful in reducing isolation and loneliness. One interviewee described how their CPS helped them to "meet with new people, friends who are similar ... we each have similar things that we're going through .... So, we talk, we laugh. They do help because I kind of always feel a bit down" (CPS Consumer Interviewee 9).

Interviewees' thoughts on CPSs' impact on their care goals or plan

Interviewees described how CPSs help consumers create more healthful lifestyles by supporting the development and achievement of goals. These goals included: exercising, healthy eating, managing daily activities, believing in oneself, and building relationships. As one interviewee stated: "So, definitely [the CPS] really helped. In fact, right now I can make a decision for myself. I can say no. I don't know. It just helps me to view this self-respect. What's the word? What's the word? Well, it's just self-respect" (CPS Consumer Interviewee 17).

Through developing better communication and connections, interviewees felt that receiving CPS services has increased their confidence, self-respect, motivation, and quality of life. Interviewees also felt better able to advocate for themselves and feel more resilient, less timid, and increasingly aware of their behaviors by being more sociable and making friends.

In terms of goal setting, most interviewees framed their comments about CPSs in recovery language. As stated by an interviewee, "[my] goals, yeah. I'm just 40. For years now, I've been addicted to [substances]. So, with the CPS, I've been able to redraw myself" (CPS Consumer Interviewee 11). Another interviewee said of their goals, "I'm just trying to build up my self-confidence" (CPS Consumer Interviewee 9). When describing their CPS, another interviewee said that the CPS "help[s] me to know some things that I need to know about life …. He'll ask me about my career and other things" (CPS Consumer Interviewee 14). CPSs were identified as being very beneficial in helping people they served to achieve their recovery goals. As one participant stated, "[My CPS] has been very helpful … developing recovery plans" (CPS Consumer Interviewee 12).

Interviewees' interactions with care teams and care coordinators

Although the focus of interviewees' conversations centered on their relationships with CPSs, comments by one interviewee about their relationship with their care coordinator stand out. The interviewee noted that a previous care coordinator had suggested massage and provided the interviewee with a typed care plan. "[The care coordinator discussed things] like pain management, massage, acupuncture and was open-minded" (CPS Consumer Interviewee 6). This quote demonstrates how the CPS's role on a care team is similar to that of a care coordinator in that both CPSs and care coordinators meet and discuss with OC members what services might help them. A CPS does not coordinate care. CPSs are people with lived experience of substance-use disorders or behavioral-health disorders and are focused on providing support to people who have similar experiences.[20] It appears that interviewees understood that care coordinators can connect people directly with needed services, and that CPSs are more recovery support-focused workers.

The interviewees' responses did not provide clear evidence of collaboration between care coordinators or care teams with CPSs, DMH, or vendors. Interviewees referenced interactions with case managers, but it was not always clear whether the

case manager worked for DMH or a vendor. It was also unclear whether interviewees' comments referred to case managers from DMH or from an OC plan contracted vendor.

Interviewees did not mention the care coordinator or other care-team members assisting them in addressing challenges with accessing CPS services or the quality of vendors. Adding to this confusion, interviewees did not know the source of their CPSs. One interviewee stated that they first heard about the availability of CPSs in OC from DPC staff, saying, "when you guys [the DPC staff] called me recently, that was the first I learned that OC has, I believe that you said, certified peer specialists direct through OC and I did not know that at all" (CPS Consumer Interviewee 7).

Interviewees described mixed feelings about case managers. Owing to high caseloads, one interviewee described how case managers, "can't always engage in longer conversations. I'm talking to my case manager about things that are financial, and it's not dealing with things that are emotional, so I don't get as much out of it as I could" (CPS Consumer Interviewee 2).

Interviewees also expressed frustration with the high turnover of case managers, as this is a barrier to their recovery. One interviewee stated, "it's difficult because I would have to go through a new case manager and try to explain to them what's it's like to lose time ... and explain this to a whole new person" (CPS Consumer Interviewee 2). Another interviewee was informed by a DMH worker that vendors were required to provide clients with specific services. The interviewee said they had "never seen" a list of services and, thus, did not know what the vendor was "supposed to be doing" (CPS Consumer Interviewee 3).

Impact of COVID on interviewees' interactions with CPSs

Interviewees highlighted the importance of communicating with their CPSs during the COVID-19 pandemic. Approximately half of those interviewed were positively affected by their interactions and connections with their CPS during the pandemic. This was primarily due to the use of Zoom and the telephone. Zoom offered meeting options of one-to-one or small groups. While some CPSs chose to meet in-person, it was noted that social distancing and mask-wearing were considered detrimental to the connection.

The wearing of masks seemed to impact the quality of conversations, as stated by one interviewee. "Yeah. They do the social distance. That's the way we have interaction. It changed the way we have a conversation. So, I tell him I kind of find it difficult to deal with his talking when the mask is covering his mouth" (CPS Consumer Interviewee 22). Another person spoke about positive aspects of virtual gatherings begun during COVID-19 that should continue:

> ... if OC were to offer a weekly online group meeting where there could be one or more certified peer specialists on a Zoom call ... and just have members be able to access not just the CPS that's assigned to them but be able to access, you know, support on a regular basis just for things that kind of come up? I think that would be cost-effective and, also, accessible to a broad number of people. (CPS Consumer Interviewee 7)

It is interesting to note that even during the COVID pandemic, people still met in person, which may speak to the value of CPSs.

Areas for improvement of the CPS program, as identified by the interviewees

Overall, interviewees appreciated the services provided by OC, but felt that it was important that OC plans connect members with CPSs who truly meet their recovery needs. Interviewees also felt that the CPS service should be expanded and more easily accessed by offering increased support by providing a greater variety of meeting times and lengthening those times to at least an hour and a half. Expanding this support would satisfy another desire for increased communication and the opportunity to see the CPS more often.

Those interviewed were very positive about the relationships and support they had developed. They suggested that CPSs' services should be publicized and shared with more people. They additionally noted that hiring more CPS workers would be beneficial. They also felt that offering CPS services that matched the gender, faith, race, ethnicity, and sexual orientation of the person receiving services would increase the connections developed with the CPS.

Equity and choice of CPSs

Enrollees raised the issue of limited racial and ethnic diversity as an area of concern in interacting with a CPS. As one enrollee stated, "I think like they should employ

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more black people because I'm black" (CPS Consumer Interviewee 9). Another person stated, "I'm black. I'm a colored person. You understand? So, we black here. Some of us feel like more or less of a person because of how we are being treated. You get the point, right?" (CPS Consumer Interviewee 12).

The point being made by this individual was clarified by other enrollees. One enrollee described their feelings about working with white peers, stating: "As a black American here, I do feel somehow grateful for all these white—not that I don't …. I like them, but I'm kind of scared sometimes" (CPS Consumer Interviewee 16). The participant indicated conflicting emotions, with gratitude often being characterized as positive and fear being characterized as negative. The participant's use of the word "scared" could indicate how racism was felt in a visceral way, perhaps rather than understood in a more logical sense or one that is based in language. Another interviewee of color described feeling "uncomfortable with discussing [their] personal issues" with a white CPS, as the interviewee apparently feared their CPS might treat them in a very unfriendly manner (CPS Consumer Interviewee 12). The comments by interviewees about race and ethnicity were summarized by another enrollee: "Sure, [the CPS] … was a good fit because, actually, it was a person of my race and ethnicity. Maybe he understood me better" (CPS Consumer Interviewee 25).

Interviewees discussed high CPS turnover and the negative impact of not having a CPS as a support. One interviewee described needing extra therapy sessions. "I miss having [a CPS] …. I don't have a social worker, I just have a case manager, and I don't have a CPS person right now, so I have less support. I've added an extra therapy

session with my therapist to try to get the extra support ...." (CPS Consumer Interviewee 2).

Vendors and program ownership

A number of interviewees were enrolled in OC and assigned CPSs either within an OC plan or through a vendor contracted by an OC. Vendors range from recovery learning communities to larger multiservice Community-Based Organizations (CBOs). It was unclear whether CPSs were provided through the Department of Mental Health or an OC plan. Interviewees identified gaps in services available through vendor organizations. One interviewee stated: "[T]he CPS provider organization has a problem with too much turn-around. It's a real problem with [Human Service Organization name], and I'm still experiencing it" (CPS Consumer Interviewee 2). That same interviewee described the value of CPSs in mitigating the effects of turnover of their care manager and other care team staff this way: "[The] CPS position is really needed to be able to bridge that gap" (CPS Consumer Interviewee 2).

It is important to note one interviewee's very negative experience. The interviewee shared concern about the professionalism of their CPS and the vendor that employed the CPS, citing a specific concern over privacy.

> [M]any people that I knew in real life were having access to information that I may or may not have chosen to share with them socially. They were having access to information through team meetings that I felt was just really unacceptable to me. (CPS Consumer Interviewee 7)

Given the intersecting relationships of people with mental-health diagnoses and CPS, it is important that firewalls be put in place to protect member Health Insurance Portability and Accountability Act (HIPAA) rights in general. More specifically, it is important to give members control over whom they share their mental-health diagnoses and experiences with on their care team.

Findings from the Key Informant Interviews

Key informant interviews were conducted with four individuals who are employed as CPSs and four representatives from OC health plans who have unique expertise in OC and in provision of recovery services. Four CPSs were interviewed because of

their expertise as professionals providing peer services. These individuals reported having a strong bond with the people they serve. Four plan representatives were chosen because of their direct connection in overseeing the implementation of OC services and knowledge of CPS services.

Feedback from CPSs about their work

CPSs felt the bond they had with people they served was strong because peers identify with their CPS's experiences. According to the CPSs interviewed for this project, the people they serve know they will always have someone to "help them" in their path toward recovery (CPS Interviewee 4) and help to "re-integrate them into the community" (CPS Interviewee 3). CPS Interviewees also discussed how they are focused on helping people feel more connected with themselves and their daily activities. As one CPS stated, "I have to make sure that I get the people … make sure that they feel happy as a person, as a human, and make sure that they get back to themselves. And also, they're engaging their daily activities and [that they] also, feel all right …." (CPS Interviewee 2).

In their work, CPSs stated that they found they were able to help individuals "become more confident" in their lives (CPS Interviewee 3), more able to figure out things themselves through setting small, obtainable goals that can bring them to new life decisions. These decisions, with the support of the CPS, assisted the people receiving CPS services in dealing with their mental-health and/or substance-misuse challenges, bringing them closer to their recovery. As one CPS cited, their role was beneficial because the people they serve "benefit from my lived experience" and the "flexibility of my work schedule" (CPS Interviewee 4).

One CPS described their role as it relates to independent living and recovery in this manner: "It's all about helping these people realize who they are, how great they are, how great they can become …. Helping them make decisions on their own, making goals, set objectives, life and well-meaning decisions. Help their will power, that's decision power within themselves. Believing they are making good quality decisions. Those decisions are good quality decisions …. So, when you become confident, you become competent in your decision making and make good quality decisions. Yeah, that's independent living" (CPS Interviewee 3). As this interviewee recognized, the CPS takes on the emotional labor involved in empowering people to better their

lives, thus giving them a unique ability to assist the people they serve in making healthy life choices.

Feedback from health-plan representatives

Results from our interviews with representatives from OC plans showed that clinical staff can be educated about the role of peer support. They are usually "excited to offer that non-clinical service to their members" (Plan Staff Interview 2). These interviewees stressed how the members need to know that a "peer specialist is available to them" (Plan Staff Interview 1). They described how peer service can be found through the "hub for peer specialists" at a Recovery Learning Community (RLC) like the Metro Boston RLC (Plan Staff Interview 2). RLCs provide crucial peer-to-peer support within and beyond a physical space, offering diverse services to individuals experiencing mental-health challenges. They are a vital lifeline for people unable or hesitant to access traditional mental-health services. RLCs support and advocate for people with mental-health diagnoses who face stigma, bias, and other barriers in conventional mental-health care. They offer community to people who too often struggle with isolation, stigma, and lack of access to other mental-health services. RLCs work with state agencies and other stakeholders to promote respect for individuals with mental-health conditions.[21]

In terms of the plans' goal for the CPS role, all of the plans' staff members expressed that they sought to connect people with community-based supports, with the goal of helping them to live more independently. As one interviewee stated: "One of our biggest missions is to keep people in the community, independent as much as possible for as long as possible" (Plan Staff Interview 2). Plans' staff indicated that they felt the CPS could supplement the roles of other care-team members. For example, if someone is in an acute crisis, the CPS can "respond after hours" and that CPSs are able to "do things more flexibly than a clinician would" (Plan Staff Interview 2). It was emphasized that the CPS's role on a care team should be consumer-directed: "The peer support does not retain any of the care-management responsibilities but is rather an added part of this individual's support network with, I think, varying degrees of engagement with the overall care team as dictated by member preference" (Plan Staff interview 1).

Another participant intimated that although at times "it can be challenging," the goal of independent living for OC members is to function "to their highest capacity"

(Plan Staff Interview 2). There are times when these members may have a "hard time opening up" about their issues (Plan staff interview 3). This could be due to stigma. One plan representative described how CPSs can help reduce that stigma: "And you know, I think we're all very aware of the role that stigma can play in individuals receiving support that can be impactful for them." As the plan representative noted, "having this group of certified peer specialists as an available support" helps with this (Plan Staff Interview 1).

Plans' staff felt that someone with "lived experience can be more helpful for them [plan enrollees]" than a clinician who has book knowledge and not actual experience. They further cited that this type of support helps OC members to identify with their peer specialist who may have "more knowledge" of the actual peer experiences, which increases their ability to reduce stigma and help with recovery (Plan Staff Interview 3).

Discussion

Interviewees described various positive aspects of having a CPS. These aspects included (1) having trust-based relationships with the CPS; (2) being able to receive recovery guidance and support because of common lived experience with CPSs; (3) reduced isolation and loneliness with the development of networks of friends in the recovery world; and (4) gaining a greater sense of control and engagement with family and other connections outside of the recovery world. These positive experiences align with findings of the research done on the impact of the peer model.[22] Interviewees also discussed barriers to the peer model, including (1) the high turnover rate among CPSs; (2) challenges with the CPS-provider organizations; and (3) lack of racial diversity of CPSs, which may perpetuate racism and lack of cultural competency.

Interviews with plan representatives revealed varying levels of understanding of recovery and the CPS role. It was expected that the interviews would yield information about integration of CPSs on care teams, but that did not occur. Interviewee data indicated no clear understanding of the source of CPSs or of ways of accessing CPSs—including accessing CPSs who share their racial or ethnic background. Some interviewees described being introduced to CPSs by DMH, while others were introduced by a friend or by their OC plan; still others seemed unsure of how they were connected.

Recommendations

There is an increasing need for effective, cost-efficient interventions to address the needs of people with mental-health diagnoses. The World Health Organization established the Mental Health Gap Action Program (mhGAP) to advance evidence-based practices to support the needs of persons with mental-health diagnoses.[23] OC offers enhanced behavioral-health diversionary services, support services, and flexible services not previously available to dual eligibles with mental-health needs.[24]

In addition to enhanced services, OC offers integrated care coordination. Taken as a whole, OC is therefore well-positioned to offer comprehensive services that address the gaps in care that impact OC members.[25] CPSs are one such intervention. The recommendations contained in this brief align with the findings of other studies and

build on recommendations put forward by the Substance Abuse and Mental Health Services Administration (SAMHSA). The recommendations listed below are not comprehensive but do outline steps that should be taken by advocates in collaboration with MassHealth and other stakeholders to strengthen the OC CPS program and overall capacity of OC to provide person-centered recovery-based services to people with lived experience of a mental-health diagnosis or trauma. It is recommended that:

A recovery model centered on the Care Model Focus Initiative. The OC Implementation Council and recovery community should work with MassHealth to establish a recovery model centered on the [Care Model Focus Initiative](#) (CMFI). The initial CMFI focused primarily on LTSS and was successful in bringing together all stakeholders to strengthen access to LTSS services in general, and to the LTSC specifically. The OC Implementation Council, along with advocates from the recovery community, should work with MassHealth to develop contract language and guidelines to increase accountability of plans and provide equitable recovery-centered care to OC members.

Adherence to recovery model. Findings indicated that CPSs and the services they provide were not integrated into the care plans of interviewees in keeping with SAMHSA guidelines.[26] Plans should be providing services in alignment with the following SAMHSA principle: recovery services should support a person in "his or her strengths, talents, coping abilities, resources and inherent values. [Recovery] is holistic, addresses the whole person and the community, and is supported by peers, friends and family members."[27] Therefore, stronger contract language and guidelines should be accompanied by a comprehensive and transparent protocol to ensure OC plans are providing integrated behavioral health to achieve equity "in a consistent and systematic, fair, just and impartial treatment of all individuals, including those who belong to underserved communities that have been denied such treatment."[28] This oversight must be implemented in an integrated fashion to ensure plans are addressing the unique needs of persons belonging to communities such as African Americans, who have been subject to intergenerational discrimination, trauma, and stigma.

No wrong door access. Based on feedback from interviewees, it is strongly recommended that *a no wrong-door approach* be taken by plans in providing peer services to OC members.

Contracting with RLCs. It is imperative that plans contract with RLCs. In contrast with in-house health-plan-run recovery services, "[c]onsumer operated services help individuals see what is possible for themselves and for others. People see the recovery is real and possible they can see it in the people surrounding them."[29] Because of the unique culture and nature of RLCs, it is important that a recovery CMFI develop strategies to enhance RLC engagement with plans that move away from Fee-For-Service (FFS) payment structures toward alternative payment models.

Increase in access to CPSs. The CMFI must reduce barriers to member access to CPSs. These barriers include underutilization of CPSs and integrated care plans within care teams; lack of adequate compensation and education of CPSs; and lack of tracking and improving the quality of CPS services.

Flexible access to CPSs. Offering individual and group CPS support during evenings and at night, either virtually (e.g., on Zoom) or in person, is needed. In addition, CPSs should be available in clinical settings such as emergency departments and medical or psychiatric hospitals.

Integration. In order for interdisciplinary care teams to meet an individual's needs, they must have access to person-centered care. This includes incorporating CPSs into care teams to communicate with people in recovery to strengthen the individual's ability to participate in healthcare decisions. CPSs can be "cultural and recovery ambassadors," bridging the divide between healthcare providers and people in recovery.[30] A key element of CPS integration is the bringing together of clinical and lived experience elements of recovery within the care team and care-planning process. CPS engagement in care teams should be enhanced to ensure recovery goals are included in members' care plan. Other elements of integration that could be improved include:

Understandable care integration. It is crucial that care integration be understandable to members. Members should have a full grasp of the relationship between their care coordinator, their case manager (if they have one), and their CPS.

Choice. Members should also have a choice of CPS and know the source of the CPS, e.g., the plan, an RLC, or another type of vendor.

Network adequacy. It is important that plans maintain network adequacy to reduce CPS turnover and gaps in access to CPSs and to ensure that all members who request CPSs can access CPSs of their choosing.

Organizational commitment. It is important that all levels of the organization be committed to integration of CPSs into care teams. This includes:

- Educating team members about the role of the CPS on care teams, ensuring CPSs have the information and support from care teams that they need to do their jobs effectively.
- Training OC CPS supervisors, giving them specifics of supervising, and supporting CPSs. Whenever possible, CPSs should be supervised by other CPSs to support the CPSs in their own recovery.
- Providing CPSs with clearly defined roles while respecting the unique relationship of peers and the centrality of confidentiality to that relationship. In practice, this means limiting plan requirements for data required of CPSs in writing notes about their interactions with individual members.

Equity. CMFI should include cross-training between CPSs and care coordinators. Training should incorporate SAMHSA diversity, equity, inclusion, and accessibility (DEIA) principles and include professional development training specific to Black, indigenous, and people of color (BIPOC) populations.[31] Interviewees' responses made it clear that ongoing training of CPSs and other mental-health professionals is necessary to reduce discrimination and increase cultural humility. These factors are important aspects of the peer model of care. In addition to training, it is necessary that policymakers, OC plans, vendors, and other entities invest in developing pathways for African Americans, Latinx people, Asians, and other minority populations to become CPSs.

Reflective of diversity. CPSs should be hired that reflect the diversity, identities, and background of the clients/consumers.

Limitations

This research was conducted using a convenience sample. Therefore, the findings are not generalizable to all OC members who have experience with CPSs in OC. The majority of respondents were from one health plan. It was difficult to track the source of interviewees' CPSs and this made it a challenge to determine quality

across different CPS providers such as RLCs and large CBOs. Additionally, interviews were conducted only in English, and the COVID-19 pandemic also impacted interviewee participation. When the research began in 2021, there were less than 10 interviewees. When outreach began again in 2022, interviewee response increased. This increase may be, in part, due to participants' comfort with Zoom and the opportunity for increased anonymity by using a pseudonym and not turning on their Zoom cameras.

All OC interviewees opted to have their Zoom cameras off for their interviews and did not want to use their cell phone numbers for these interviews. In addition to these challenges, one person falsely claimed to be eligible to participate in the study and attempted to go through the interview process twice. In response to this breach, the DPC staff reviewed transcripts of interviewees to check for potential discrepancies in the interview content. Another individual who claimed to be working as a CPS in Massachusetts was ultimately found during their interview to be ineligible to participate in this project, as they had always worked as a CPS in another state.

Appendices

Appendix A: Demographics of Interviewees receiving CPS services

The table below details basic demographic data for individuals we interviewed who used CPS services. The majority of these individuals were Black (67%), non-Hispanic (58%), males (67%), between the ages of 21 and 30 (64%), and members of one health plan (64%). Regarding their sexuality, many interviewees (67%) stated they were heterosexual. Most interviewees (33%) reported that they were connected with a CPS via RLCs. Some interviewees (18%) stated they were connected with a CPS via a variety of sources like friends or social media. We classified these sources as "other," as these sources appeared to be outliers.

Characteristics	Number	%
Age		
21–30	21	64%
31–50	6	18%
51+	6	18%
Gender		
Female	11	33%
Male	22	67%
Race		
Black	22	67%
White	9	27%
Latino	1	3%

No Answer	1	3%
Ethnicity		
Hispanic	12	36%
Non-Hispanic	19	58%
No Answer	2	6%
Sexuality		
Bisexual	4	12%
Gay	3	9%
Heterosexual	22	67%
No Answer	4	12%
Health-Plan Membership		
Plan A	11	33%
Plan B	1	3%
Plan C	21	64%
How connected with CPS		
Community-Based Organization	6	18%
Human Service Organization	6	21%
RLC	11	33%

Other	6	18%
Can't remember/No answer	4	12%

Appendix B: Demographics of interviewees who are CPSs

Interviewees who both received CPS services and served as CPSs were fairly uniform in their demographics. Most of these interviewees were heterosexual males between the ages of 21 and 30. All CPSs who were interviewed identified themselves as being Black and the majority identified as non-Hispanic. They were all insured by Healthcare Plan C and most stated they were connected to people needing CPS services through their friends.

Characteristics	Number	%
Age		
21–30	3	75%
31–50	1	25%
Gender		
Female	1	25
Male	3	75%
Race		
Black	4	100%
Ethnicity		
Hispanic	1	25%

Non-Hispanic	3	75%
Sexuality		
Heterosexual	3	75%
Other	1	25%
Health Plan Membership		
Plan C	4	100%
How connected with clients		
Through friends	2	
RLC	1	
No answer/Can't remember	1	

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