

State-funded Peer Support Definition FAQ

1. How can one become a Certified Peer Support Specialist?

Information for how to become a Peer Support Specialist can be found at:

<https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/certified-peer-support-specialists/information-community-members#BecomeaCertifiedPeerSupportSpecialist-6411> or <https://pss.unc.edu/certification>

2. How much does the course cost?

The State Standardized Curriculum, Foundations of Peer Support is Track A, both the online and in-person course is free of charge. Track B is a different certification course which does come with a cost associated. Please reach out to program staff if you have additional questions on how to enroll in the person portion after completing the online portion. Nccpssprogram@unc.edu

3. Why is there two-point authentication for telehealth?

Two- point authentication is decided upon by the CPSS and individual. The CPSS will want to make sure it is approved by their provider's policies. Two-point authentication is also important to ensure you are not violating HIPAA by accidentally divulging information to the wrong individual.

4. Why is there a start and end time requirement?

Tracking dates and times of interactions ensures that billing times are accurate. For an individual to know how long they have been with the person being served. To bill they also need to know the start and stop to ensure the service length reported is appropriate.

5. Why is the National Accreditation timeline to be completed within one-year?

The National Accreditation requirement was in the State-funded policy prior to this revision. Organizations who are actively billing state-funded services are already under the national accreditation requirement (NCGS 122c-81) and must be accredited within one-year of enrollment. This is not a new policy.

6. What can the policy do to ensure providers do not make CPSS bring their own clients?

Providers directing CPSS staff to recruit clients from personal networks rather than using established referral processes constitutes an ethical violation and should be reported to the appropriate LME/MCO. Concerns of this nature would not be addressed within policy.

7. Does the definition follow SAMSHA guidelines?

SAMHSA guidelines and practices, as well as requirements necessary to implement the service consistently across state-funded and Medicaid rules and regulations, were taken into consideration throughout the process of the update.

8. Why not make the CPSS definition about case management?

Peer Support is not the same as case management. A CPSS should not be doing case management duties and should not be functioning as a case manager.

According to SAMHSA “PSSs provide support services to individuals experiencing similar challenges, and they perform a wide range of nonclinical community-based activities, including: advocacy, system navigation, and linkage to resources. PSSs do this through sharing experience, social support, group facilitation, skill building, mentoring, and goal setting towards sustained recovery process.” This is a different process and approach than case management.

9. Why are NC Tracks guidelines not included in the state-funded definition?

NC Tracks is the statewide gateway for network participation. However, the LME/MCOs have the leeway to limit the number of providers in their network as long as they ensure adequacy of the network for that service. Medicaid plans are at the discretion of the NCDHHS Division of Health Benefits (DHB). Please refer to page 27 of the State-funded definition for more information about NC Tracks.

10. What is being done to protect and develop the Peer Support Workforce?

Peer Support Workforce does receive requested assistance from the NC CPSS Program. This includes technical assistance for both providers and CPSS looking for employment. They offer trainings to help further their careers, job linkage, resume writing support, and more.

<https://pss.unc.edu/workforce-tech-assistance>

11. Why are peer support services embedded into the clinical teams for the state-funded definition?

CPSS services can be used to complement clinical services. The inclusion of CPSS into clinical services does not mandate an individual in receiving clinical services to receive peer support. It helps the individual receive services quickly if they request the clinical services.

The MOU/MOA for medication management is meant to assist individuals in obtaining services quickly rather than the CPSS handling any of the medication management needs after the referral process.

12. What does “similar lived experiences” mean?

The policy states in Section 1.0; “PSS services is directly provided by North Carolina Certified Peer Support Specialists (CPSS) who have self-identified as a person(s) in recovery from a mental health or substance use disorder.” This statement supports that a CPSS may have lived experience with mental

health or substance use disorder. Section 1.1.8 defines Lived Experience: “Lived Experience is personal knowledge, awareness, and understanding gained through direct involvement in life events, particularly those related to mental health, substance use, and recovery.” The policy does not require identical diagnosis, treatment history, or life circumstances. The term similar lived experiences support individuals sharing like experiences to be able to relate and support the individual’s recovery journey. Similar does not mean exact.

13. Does the state recognize community-based approaches to peer support?

This is the CPSS service definition for state-funded billing, but the Division understands and is supportive of all peer agencies to include peer run organizations. The definition is not meant to be inclusive of all peer support services.

14. Does the state-funded definition allow for text-based communication?

Telehealth and telephonic services can be used to help support an individual in a tight time frame and limiting travel times. The provider can use up to 10% of the individual’s monthly time in a telehealth or telephonic setting. PSS is meant to be done with the individual in a community setting as much as possible. The telehealth procedure can be found here: <https://www.ncdhhs.gov/state-funded-telehealth-and-virtual-communications-services-11-1-21/download?attachment>

15. Why is the authorization period 60 days?

The NCDHHS Utilization Management Review Contractor may authorize medically necessary PSS at the clinically appropriate amount, duration, and frequency. Authorization timeframes and unit thresholds are intended to guide utilization review frequency and do not limit authorization of medically necessary services supported by documentation.

When it is medically necessary for PSS to be authorized for more than nine months, a new CCA or an addendum to the original CCA and a new service order must be completed and submitted with the reauthorization request. Reauthorization requests beyond nine months must be reviewed and reauthorized every 30 calendar days.

This means that re-authorizations can be extended beyond the 60-day period based on the level of need, but the 9-month review period allows for a review of the individual’s needs to access for a higher or lower level of care.

16. Is the state-funded definition available for transition age youth?

CPSS is meant for individuals 18 years of age and older. The definition does not limit transition services. It does not allow for duplicative services to be billed at the same time of day.

17. How should the recovery goals be defined?

As stated in Section 1.0 the Description of the Service it shows CPSS is a self-guided service by the individual. “Providing one-on-one support builds on the relationship of mutuality between the individual and the CPSS; supports the individual in accomplishing self-identified goals; and may further support the individual’s engagement in treatment. Peer Support Services provided in a group setting allow the individual the opportunity to engage in structured services with others that share similar recovery challenges or interest; improve or develop recovery skills; and explore community resources to assist the individual in their recovery. PSS interventions are based on the individual's needs and goals and are coordinated within the context of the individual’s Person-Centered Plan.”

This is also reiterated again in the chart titled Certified Peer Support Specialist where it discusses the job duties and role of the CPSS with the individual.

18. Are the list of recovery goals a complete list?

The recovery goals provided in the definition are meant to be examples and not a comprehensive list of recovery goals used in the community.

19. Who provides oversight of agencies?

Oversight of provider agencies is the responsibility of the contracted health plans. Each health plan has a Provider Manual that includes details about their monitoring and oversight of providers. Provider contracts with the health plans also detail additional oversight and reporting requirements of the contracted health plan. Stakeholders including provider staff, individuals served, or legally responsible person(s) may report ethical violations to the health plans through their Ethics Points portal.

20. Does the state-funded definition mandate clinical services?

The State-funded definition does not require an individual to be enrolled in clinical or medication services. The definition states that the service will be housed in an office with those services. This ensures that an individual has access to services if they are requested.

21. What are the program supervisor’s qualifications?

The Program Supervisor must be a Qualified Professional (QP) in order to complete the needed assessments. The term Program Supervisor helps show the individual’s job title and differentiate between the CPSS and the Supervisor job duties. Some CPSS are QPs and in turn using the term QP could cause clinical drift within the CPSS scope of work. An individual employed as the CPSS and not as the Program Supervisor even if rising to the level of a QP should not be doing assessments.

The Program Supervisor qualifications and role is defined in Section 6.2.1 Staff Requirements; “The PSS program must be under the direction of a full-time QP who meets the requirements according to 10A NCAC 27G .0104 or equivalent federally recognized tribal code or federal regulation.

22. Will the training and implementation mandates require additional resources (i.e WRAP and Opioid Antagonist Administration Training)

Opioid Antagonist Administration Training can be found for free on the CDC website here:

<https://www.cdc.gov/overdose-prevention/hcp/trainings/talking-about-naloxone.html>

The North Carolina State Naloxone Trainer also provides free trainings via an email request

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In regard to the WRAP training, those are additional training options or recommended trainings, but are not mandates. “Additional training options for all PSS program staff include”

23. Can guidance be given on PCPs and when signatures are required?

PCPs require signatures from the providers and the individual. The PCP guidance document can be found

here: <https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/councils-and-committees/person-centered-planning>