

Report to the Legislature

Evaluating Potential Transfer of Peer Counselor Certification Program

December 2019

Chapter 446, Laws of 2019



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Executive Summary

[Chapter 446, laws of 2019](#) (52(1)) directs the Department of Health (department), with cooperation from the Health Care Authority (authority), to conduct a sunrise review under [chapter 18.120 RCW](#) to evaluate transfer of the peer counselor certification program from the authority to the department with modifications for the credential to be subject to oversight, structure, discipline, and continuing education typical of other behavioral health credentials.

The department received mixed public comments on whether to maintain the current certification program under the authority or transfer it to the department. However, in considering the public comments in combination with our analysis under the sunrise statute, the department finds no compelling reason to recommend transferring this program. Namely, the department did not hear evidence of an overwhelming need to protect the public by restricting entry into the profession (requiring certification for all peer counselors), which is the intent of the analysis under the sunrise statute, [RCW 18.120.010\(1\)](#).

Potential positive effects of the transfer are:

- A statutory scope of practice could create consistency by clearly defining practice limits;
- All peer counselors would fall under the Uniform Disciplinary Act (UDA) under chapter 18.130 RCW¹ rather than just those credentialed as agency-affiliated counselors and working in licensed behavioral health agencies²; and
- Certification under Title 18 RCW could make peer counselors an eligible provider type to receive private insurance reimbursement and expand peer services beyond behavioral health agencies.

Potential negative effects of the transfer are:

- The cost of training, examination, credentialing, discipline, and continuing education would be passed on to applicants to meet the statutory requirements for professions to be self-supported³, creating a potential barrier to entering this field;
- Peers may be perceived as clinical care providers, which could shift the power dynamic from equals to a peer-client relationship through their affiliation with the health care system and impact the trust on which the peer model is based; and
- Creating a statutory scope of practice for peers could make the services provided by Alcoholics Anonymous programs and community health workers unlicensed practice.

¹ The UDA provides the statutory legal and policy framework for regulation and oversight of health care professions.

² Peer counselors working in behavioral health agencies must currently be credentialed as agency-affiliated counselors for Medicaid reimbursement.

³ RCW [43.70.250](#).

Background

Legislative Request

[Chapter 446, laws of 2019](#) (52(1)) directs the Department of Health (department) with cooperation from the Health Care Authority (authority), to conduct a sunrise review under [chapter 18.120 RCW](#) regarding peer counselor certification. The department is directed to evaluate transfer of the peer support counselor certification program from the authority to the department with modifications for the credential to be subject to oversight, structure, discipline, and continuing education typical of other department-issued behavioral health credentials. The credential must allow for grandfathering of current individuals who hold the peer counselor certification.

As part of its review, the department must evaluate the effect of these potential modifications on professionalism, portability, scope of practice, approved practice locations, workforce, bidirectional integration, and appropriate deployment of peer support services throughout the health care system.

Chapter 446, laws of 2019 (Section 52(2)) also directs the department to conduct a sunrise review to evaluate the need for creation of an advanced peer support specialist credential. Findings from this evaluation will be reported separately to the legislature.

Current HCA Peer Counselor Program

The services peer counselors are authorized to perform in Washington are not in statute or rules, but in the *Medicaid (Title XIX) State Plan* (state plan). The state plan is “the officially recognized statement describing the nature and scope of Washington’s Medicaid program” and it is required to qualify for federal funding for Medicaid services.⁴

According to the state plan, “certified peer counselors (CPCs) work with their peers (adults and youth) and the parents of children receiving mental health or substance use disorder services. They draw upon their experiences to help peers find hope and make progress toward recovery. Because of their own life experience, they are uniquely equipped to provide support, encouragement and resources to those with mental health challenges.”⁵

The peer counselor certification program is currently administered by the authority’s Peer Support Program and requirements for certification are specified in the state plan. Prior to July

⁴ <https://www.hca.wa.gov/about-hca/apple-health-medicaid/what-state-plan>, accessed July 1, 2019.

⁵ Health Care Authority web site, <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/peer-support>, accessed July 1, 2019.

1, 2019, Medicaid only covered mental health peer services, but the state plan has been amended to include substance use disorder peers ([2019 state plan amendment](#)).

Requirements for certification include:

- Self-identification as a consumer, or parent or legal guardian of a consumer, of mental health or substance use disorder services;
- Certification as an agency-affiliated counselor under chapter 18.19 RCW⁶;
- Completion of online prerequisite course;
- Completion of a 40-hour specialized training course⁷ on core competencies established by the federal Substance Use and Mental Health Services Administration (SAMHSA);
- Passage of an examination administered by the authority; and
- Receipt of a written notification letter from the authority recognizing the individual as a certified peer counselor.⁸

The authority's peer support program is funded through grants from SAMHSA. Through these grants (approximately \$1.5 million in 2018), the authority is able to provide free trainings throughout the state either through the authority's contracted providers or through regional behavioral health organizations. For regional trainings, the costs of training, training materials, and the exam are covered. For the two statewide trainings offered, lodging and meals are also covered. The program also covers continuing education for the peer workforce, an annual conference, and training and technical assistance to agencies providing peer support services.⁹ It is unclear whether the SAMHSA funds that support these program activities could be transferred to the department if the program moves out of the authority.

We estimate there were 2,372 certified peer counselors in 2017, based on the number of peers that were trained and certified.¹⁰ This number may not reflect the actual number of peer counselors working in the field today because certification is not required for all peer counselors and there is no annual renewal. Also, some who were certified may have stopped practicing.

⁶ Necessary for Medicaid reimbursement.

⁷ Training and examination costs are covered by HCA through SAMHSA funds.

⁸ Health Care Authority web site, <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/peer-support>, accessed July 1, 2019.

⁹ Washington State Health Care Authority Peer Support Program Overview, December 2018, <https://www.hca.wa.gov/assets/program/fact-sheet-peer-support-program.pdf>, accessed September 24, 2019.

¹⁰ Nova Gattman et al., "Washington State Behavioral Health Workforce Assessment," Washington State Workforce Training and Education Coordination Board and University of Washington Center for Health Workforce Studies, December 2017, Attachment B.

Certified peer counselors work in licensed behavioral health agencies and receive Medicaid reimbursement. To be eligible for Medicaid reimbursement, peers must also hold an agency-affiliated counselor (AAC) credential from the department. While the authority's peer counselor certification alone carries no regulatory oversight, when peers are credentialed by the department as AACs they are subject to the Uniform Disciplinary Act (UDA) under chapter 18.130 RCW. The current fees for an AAC credential are \$90 for initial registration and \$75 for annual renewal. Peers are allowed to work in other settings, however they are not allowed to bill Medicaid for services in any setting outside a licensed behavioral health agency. The number of peer counselors working outside of agencies is unknown.

Overview of DOH behavioral health credentialing programs

The department regulates 497,000 practitioners across 86 health professions, including 19 behavioral health professions. Regulated health professions have a scope of practice—and often education, training, examination, and supervision requirements—established in law by the legislature. The authority to practice a given health profession is limited to those who have met the requirements and are credentialed. With the exception of agency-affiliated counselors, almost all credentialed health professionals may work in any setting and receive any type of reimbursement.

To receive a credential, health professionals must provide documentation that they have met the legal requirements for licensure and are able to practice safely. To assess an applicant's ability to practice safely and prevent risks to the public, the department may conduct criminal background checks. If a substance use disorder is found, the department may offer a contract in a substance use monitoring program in lieu of an application denial.¹¹

Regulated health professions are subject to the UDA for their conduct. The department receives complaints from the public about health professionals and conducts investigations. If allegations are substantiated, the regulatory authority (the secretary of health or a profession-specific board or commission) carries out discipline (e.g., license suspension or revocation). The disciplined health professional has rights to an appeal under the UDA.

State law ([RCW 43.70.250](#)) requires that the cost of regulating a health profession be borne entirely by those that are licensed or credentialed. The department recovers the cost of

¹¹ Chapter 444, laws of 2019 and chapter 446, laws of 2019 modified substance use monitoring program participation for agency-affiliated counselors practicing as peer counselors. These individuals may not be required to participate in substance use monitoring if they have at least one year in recovery. If they have less than one year in recovery, they may only be required to participate in monitoring for the amount of time necessary to achieve one year in recovery.

regulation through fees charged for obtaining and renewing a credential. Costs of education, examination, and continuing education are typically covered by the applicant. Based on fees charged to similarly sized professions, we estimate that the initial license fee for peer counselors credential by the department could range from \$81 to \$555.¹²

Regulation of Peer Counselors in Other States

Forty-one states and Washington D.C. have jurisdiction-approved programs to train and certify mental health peer counselors or specialists. At least 13 states have established certification for substance abuse peer specialists. Many of these programs are run through state Medicaid programs and all but eight states are authorized to bill Medicaid for peer services through Medicaid State Plan amendments or Medicaid waivers. The number of peer counselors or specialists certified in each state ranged from 16 (North Dakota) to over 4,300 (Pennsylvania).¹³

Requirements for certification typically include: lived experience with a mental health condition or substance use disorder, currently being in recovery, completion of a training program, and passing an examination. The training programs range from 40 hours to 100 hours. Some states require hours of paid or volunteer experience (up to 2,000 hours in some states) and continuing education for renewal of the certification.¹⁴

The department could not identify any state that requires credentialing for all peer counselors. Our research showed similar requirements to Washington, where certification is required for Medicaid reimbursement of peers working in state-regulated facilities or agencies.

Because standards for training and certification vary from state to state, portability may be challenging. There are national and international certifications creating consistent standards:

- The International Certification and Reciprocity Consortium offers a peer recovery certification for individuals with lived experience in recovery from addiction, mental illness, or co-occurring substance and mental disorders;
- Mental Health America offers a national certified peer specialist certification;¹⁵ and

¹² Based on the estimate of 2,372 peer counselors, comparing with similarly sized professions and without data on disciplinary rates, which could have a large impact on fee amounts. Dietitians and nutritionists pay \$81 and have low disciplinary rates and SUDPs pay \$555 and have high disciplinary rates.

¹³ Laura Kaufman, M.A. et al., "Peer Specialist Training & Certification Programs: A National Overview 2016," Texas Institute for Excellence in Mental Health, University of Texas at Austin.

¹⁴ Ibid.

¹⁵ Susan Chapman et al., "Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders," *American Journal of Preventive Medicine*, Vol. 54, Issue 6, Supplement 3, June 2018, p. S272.

- National peer support recovery specialist certification is offered through the Association for Addiction Professionals. This certification is for individuals in recovery from substance use or co-occurring mental health disorders.¹⁶

Stakeholder Engagement

To gather initial information on the potential positive and negative effects of transferring the peer counselor certification program to the department, the agency held focus groups with stakeholders in August. The groups included behavioral health agencies, peer support advocacy organizations, and peer counselors. Representatives from the authority were at the meeting as well.

Participants were asked to express their thoughts regarding the potential effects on professionalism, portability, scope of practice, approved practice locations, workforce, bidirectional integration, and the deployment of peer services in the health care setting. Participants were also asked questions related to our analysis under sunrise reviews ([chapter 18.120 RCW](#)), including whether department regulation could potentially: better protect the public, harm the public by unnecessarily restricting entry into the profession, or increase access to services.

To guide their thinking about potential positive and negative effects of creating a department-regulated peer counselor profession, participants were asked to assume the following:

- A credential would be required by law for anyone who practices peer counseling, regardless of practice setting or reimbursement;
- Credentialed peer counselors would no longer need to get a separate agency-affiliated counselor credential;
- Scope of practice would be restricted in statute and protected from unlicensed practice;
- Training and testing could continue to be delivered through the authority or through private entities;
- Fees would be set at levels sufficient for the profession to be self-supporting as required in RCW 43.70.250; and
- All peer counselors (including those working outside a community behavioral health agency) would be subject to the UDA.

¹⁶ NAADAC, The Association for Addiction Professionals Web site, <https://www.naadac.org/NCPRSS>, accessed September 12, 2019.

Once the department gathered input on the positive and negative effects of transferring the peer counselor program, we developed a draft report. We shared this draft report with stakeholders for written comments in early September and held a public meeting for oral comments in late September. Comments are summarized in the next section.

Summary of Public Comments

Stakeholders identified the following themes regarding positive effects of transferring peer counselor certification to the department through a focus group discussion, written comments, and oral comments at a public meeting:

- Having a single agency defining standards and overseeing the profession could create consistency within the profession, which could also increase quality of care for consumers;
- A clearly defined scope of practice and protection from unlicensed practice would standardize requirements for practicing as a peer counselor;
- Credentialing peer counselors as a regulated profession would help peers be seen as equals to other health care professionals;
- Credentialing peer counselors could facilitate integration of peers into the health care system and could help reform the medical model so behavioral health is a priority and treated with respect (this was also listed as a potential negative effect – see below);
- Expansion of peer counseling outside licensed behavioral health agencies could be a positive effect if oversight is clearly defined;
- Credentialing peer counselors could lead to use of this model in hospital emergency departments; and
- Credentialing peer counselors would allow for reimbursement options beyond Medicaid,¹⁷ which would increase access to care outside behavioral health agencies.

Stakeholders also identified a number of potential negative effects of transferring the credential:

- Placing peers in a clinical landscape could erode peer support in the recovery process because peers would shift into a professional role;

¹⁷ Per the Office of the Insurance Commissioner, in order to be reimbursable under private insurance, the provider of the covered service must be licensed (or certified) under title 18 or chapter 70.127 RCW, or be supervised by or the agent of such a licensee.

- Moving the program to a regulatory agency could also impact the core spirit of peer counseling by changing it from the current “recovery model” to a “medical model,” which are different philosophies;
- The potential for peers to no longer deliver the training is a large concern for peer counselors working in the field.
- Credentialing peer counselors could limit the growth of the workforce by increasing barriers to entry due to:
 - The cost of training, examination, and continuing education;
 - The potential for higher fees since the program would have to be self-supporting by law; and
 - Potential backlogs in getting credentials if application requirements expand.

Stakeholders provided additional suggestions for consideration including:

- Removing “counselor” from the peer counselor title to avoid consumer confusion;
- Clarifying the definition of peer roles; and
- Defining appropriate supervision, especially in settings outside behavioral health agencies.

Conclusion

The department received mixed public comments on whether to maintain the current certification provided by the authority or transfer the program to the department. However, taking into consideration the public comments in combination with our analysis under the sunrise statute, the department finds no compelling reason to recommend transferring this program. Namely, the department did not hear evidence of an overwhelming need to protect the public by restricting entry into the profession (requiring credentialing of all peer counselors regardless of practice location or reimbursement), which is the intent of the sunrise statute, [RCW 18.120.010\(1\)](#).

The department found potential positive effects of the transfer, such as clearly defining practice limits in a statutory scope of practice; having all peer counselors under the UDA; and making peer counselors an eligible provider type for private insurance through certification under Title 18 RCW. The department also found a number of potential negative effects, such as the requirement for applicants and credential holders to pay the full cost of the regulatory program; shifting the power dynamic from equals to a peer-client relationship and potentially impacting client trust in peers; and inadvertently restricting peer services provided by others such as community health workers by establishing a statutory scope of practice for peers.

The department found the following potential effects on the topics requested in the bill:

- **Professionalism:** If credentialed by the department, peers may be perceived as clinical care providers. This would shift the power dynamic from equals to a peer-client relationship through their affiliation with the health care system. This would, in turn, impact the trust on which the peer model is based.
- **Scope of practice:** There are benefits to a statutory scope of practice for all peer counselors in Washington, such as consistency and clearly defining practice limits. However, it could also inadvertently preclude provision of services that overlap with peer counseling, such as Alcoholics Anonymous or community health workers.
- **Workforce:** The transfer could positively impact the workforce because credentialing peer counselors under Title 18 RCW could make them an eligible provider type to receive private insurance reimbursement outside behavioral health agencies.¹⁸ However, the costs of training, examination, licensing, renewal, and continuing education could create a barrier to entering this field. The authority's peer certification program currently covers all of these costs through SAMHSA grants. State law requires

¹⁸ Please note that hospitals can already hire agency-affiliated counselors who are certified peer counselors because the AAC law requires them to be an agency licensed by the state. They don't need to be a licensed behavioral health agency.

the department's credentialing programs to be self-supporting, which means costs would be passed on to the applicants.

- **Approved practice locations/appropriate deployment of services:** If the department credentialed peer counselors, they would have expanded reimbursement options and could practice in settings outside behavioral health agencies. However, the workforce impacts identified above may also negatively impact access to services if the number of peer counselors is significantly reduced because of cost barriers.
- **Portability:** There would most likely be little impact on portability to other states because training and certification requirements vary greatly from state to state. There are already national and international certifications that are available and create consistent standards many states accept for reciprocity.
- **Bidirectional integration:** Transferring peer counselors to the department could positively impact bidirectional integration because a department credential issued under Title 18 RCW would make them an eligible provider to receive private insurance reimbursement and expand peer services beyond behavioral health agencies.

Appendix A: Stakeholder Input

Stakeholders provided the following input on potential positive and negative effects of a department-credentialed peer counselor:

Positive Effects	Negative Effects
<p>1. Professionalism¹⁹</p> <ul style="list-style-type: none"> • A single agency responsible for defining standards and overseeing the profession would increase consistency • Would be recognized on par with other professionals • The risk of losing a license for unsafe engagement with clients is good 	<p>1. Professionalism</p> <ul style="list-style-type: none"> • It could place peers in the clinical landscape, which could erode peer support in the recovery process because peers would shift into a professional role • Could create confusion about the peer role • Could change the core spirit of the peer counselor program. Moving it to DOH might change it to a “medical model” rather than the current “recovery model” and the two have very different philosophies
<p>2. Portability</p> <ul style="list-style-type: none"> • Could increase transferability to other states • Could allow billing for private insurance 	<p>2. Portability</p> <ul style="list-style-type: none"> • Could increase barriers to portability • Concern that DOH would need to assess criminal history of those wanting to transfer certification from other states
<p>3. Scope of practice</p> <ul style="list-style-type: none"> • Would have protection from unlicensed practice • Could be clearly defined, limited, and standardized 	<p>3. Scope of practice</p> <ul style="list-style-type: none"> • Concerns with peers practicing independently. If an advanced peer support specialist is created, that would make this less of a concern • Could limit the number of peer counselors • Could be off-putting to those looking for help • Credentialing and supervision requirements could limit access to peer support in non-Medicaid agencies
<p>4. Approved practice locations²⁰</p> <ul style="list-style-type: none"> • May expand locations to non-medical settings • Expansion outside behavioral health agencies could be positive as long as a proper infrastructure is in place 	<p>4. Approved practice locations</p> <ul style="list-style-type: none"> • “Peer” title is a barrier in some locations (EDs, hospitals, etc.) • Could be a negative impact to practice locations

¹⁹ A few stakeholders suggested peer counselors be re-named to remove “counselor” from the title to help avoid confusion on their role.

²⁰ There were a number of responses that weren’t positive or negative: Completely peer-run organizations should be supported by licensure to operate. Funding and training needs to stay the same.

Positive Effects	Negative Effects
<p>5. Workforce</p> <ul style="list-style-type: none"> • Could create advancement opportunities for peers in the workforce • Could hold agencies more accountable for their role in supporting peers • Could allow peers to be recognized alongside other behavioral health employees 	<p>5. Workforce</p> <ul style="list-style-type: none"> • Could reduce the workforce because some peers have had bad experiences with DOH through their agency-affiliated counselor credential • Agencies could be negatively impacted by peer workforce reduction • Concerns with availability of training and access to it • Concerns that certified peer counselors won't continue to do the trainings • Start-up fees for this program could be prohibitive because DOH programs are required by law to be self-supporting
<p>6. Bidirectional integration²¹</p> <ul style="list-style-type: none"> • Could be improved if private insurance could be billed • Could be positive if you hire the right people 	<p>6. Bidirectional integration</p> <ul style="list-style-type: none"> • The recovery model is not effective in the medical setting so peer support could be less effective • There is already a severe workforce shortage and this could make it worse
<p>7. Appropriate deployment of peer support services throughout the health system²²</p> <ul style="list-style-type: none"> • Could allow peer support to integrate with the medical recovery model to bridge the gap and create cohesion among providers • Could create peer support in emergency rooms • Could increase reimbursement options • Could have positive impact if peers give the training • Could be an advantage as long as the protocols for deployment align with scope of practice • Could be an advantage if the credential is flexible for non-Medicaid programs 	<p>7. Appropriate deployment of peer support services throughout the health system</p> <ul style="list-style-type: none"> • Potential additional application requirements could create backlogs and barriers to entry into the profession • If there are additional training and supervision requirements, it may impact how many apply for certification and reduce the workforce

²¹ There were also questions asked: What does peer mean in the primary care setting – peers support both behavioral and physical health. What barriers could be overcome, such as training costs, so people can continue to enter the field?

²² Questions posed by stakeholders: Will DOH offer specific training and continuing education based on a peer's lived experience and recovery to determine appropriate placement in the health system? How would DOH ensure that the peer counselor has in fact "lived experiences" to actually help a peer in a certain situation.

Stakeholders identified the following potential impacts on public protection and access to care:

Positive Effects	Negative Effects
<ul style="list-style-type: none"> • It could address barriers, creating opportunities for community based recovery organizations to become licensed • Standardized education and continuing education for all peer counselors could help with quality of care • Under current law, consumers can only complain about certified peer counselors, not those working outside behavioral health agencies. This change would standardize the laws to protect the public • It could increase access to care if it leads to billing private insurance 	<ul style="list-style-type: none"> • Would have no impact because the agency-affiliated counselor credential already has built in protections • If peers can't access the required training it could limit access to peers by clients • It could harm the public - more barriers and higher fees may equal fewer peers in workforce • It could harm the public dependent on how the scope of practice is defined • Substance use disorder monitoring can be a barrier to people entering the workforce • It may not increase access to care unless it leads to the ability to bill private insurance

Summary of Public Comments on Draft Report

I am currently employed as a Peer Support Specialist, I have been working for 5 years. Personally, I think there is too much to lose to transfer the credentialing. Department of Health will make it hard for those who have criminal backgrounds/ sud histories to be credentialed; the process will take longer regardless of histories for everyone. The cost of credentialing will increase and our trainings will no longer be free. I have attended several trainings to continue my education; without those trainings I would not be equipped to do this job. I do not make enough money to pay for trainings or more credentialing fees, this transfer does not increase my wages. I lose money and education. The people I support will be losing care because I will not have access to the same amount of continuing education.

The HCA has been regulating peer counselors effectively and training them. DOH has no promises of having our certified peer counseling training remain within peers teaching peers. There is no guarantee that the recovery model is going to stay; there is limited recovery language in the proposal to switch. I do not feel comfortable in DOH's ability to support or mold their model to fit what the peer model needs to remain true peer support. Most importantly, I believe the field that will lose trust from the peers they support because we would be "one of them" is the mental health professional. Peer supporters are professional people who have

lived experience in behavioral health not mental professionals (value of peer support). We are effective because we hold the hope and the trust of those in services. The credentialing will break that trust in my opinion. Peer service will not be as effective or beneficial to those enrolled in services. It was cited in the proposals as well. "Placing peers in a clinical landscape could erode peer support in the recovery process because peers would shift to a progress role. Moving the program to a regulatory agency could also impact the core spirit of peer counseling and may change it from the current "recovery model" to a "medical model" which are different philosophies." I couldn't say it better myself.

During the Peer Pathway's conference I went to a discussion about DOH and peer support. Listening to the presenters humbly disclose not knowing what peer support was or our scope of practice was concerning. Yes, they may be learning and trying to make it work, but HCA already has the understanding of peer support, so transferring us to DOH doesn't make sense to me. Again, I feel like there is too much to lose; the costs of this change greatly outweigh the potential benefits in my professional opinion.

Alicia Santoro, CPC
Peer Support Specialist

Department of Health should oversee all health care professional licenses. Consistency is essential for standardizing educational and ethical requirements.

Nancy K Murphy, LMHC

After reading about the proposed House Bill 1907 (Sec 52), I would like to share my thoughts and comments briefly. I recently completed the Peer Support Specialist Program or Certified Peer Counseling (It does need a new name). My experience was one of pleasant surprise. I was skeptical that a bunch of untrained, recovered addicts and mental health patients could be utilized in areas where generally highly trained and schooled therapists, counselors and doctors have difficulties. My experience was that there was a level of understanding and shared experience in the group that you do not get from these mental health professionals. Speaking from my experience in the class, I felt like I was an equal amongst peers.

This experience is essential in mental health treatment. Too often patients are subjugate to the authority of the institution, advised by people that lack the personal experience to truly understand many issues at a deep, essential level. Often the simplest solutions offer the greatest return with the smallest investment. The Peer Support Program is a great example of this.

Looking over the proposed bill and the proposed requirements, I worry that by adding too much red-tape and requirements will undermine the proven success of the program thus far. I have experience as a licensed massage practitioner. In my time doing massage, I was required

to complete continuing education credits on a regular basis. This was difficult for me both financially and in finding time. Often the classes were second rate, expensive and exploitive. Continuing education providers know of the essential need for these services and often overcharge and provide a poor product for the money. It will be difficult to keep the genuine peer support at the level it is today if too many boundaries are set to entry. I can imagine that many Peer Support Specialists over time will seek out more education and schooling as they start seeing the results of their work and the impact it makes on the people they are working with. The Peer Support Specialist role is a dream come true for the majority who do it. No one wants to help and share more than someone who has felt the debilitating pain and helplessness of addiction and depression and somehow overcame it to find peace and happiness again.

In conclusion, the Peer Support Specialist Program helps not only the patients in a multitude of ways that trained and schooled professionals cannot achieve, but it also provides confidence, security and a sense of belonging to the CPC's as well. It would be a mistake to make the entry into such a complex role as it would deter many of the people that have the most to share and the most to offer. I applaud the clarity of mind that brought about this program and the practicality of keeping the threshold to entry accessible. In this field, I believe those who have the most to offer often have a lack of trust towards the authorities and adding more red-tape could scare off the best ones.

Michael J. Cabbage

I haven't been given a whole lot of information as to why or the benefits of the CPC changing from the Health Care Authority to the Dept. of Health. In my experience though, the Dept. of Health will mangle and micromanage a genuine role into another social services cop role that I would not want to touch. As it stands, the job descriptions for peer counselors are ridiculous and are equal to the role I had as a case manager before my disabilities got to the point I could no longer continue that role. Instead, I put my knowledge, experience and compassion into being a peer and becoming a CPC and I cannot find employment as that because of the incredulous demands placed on individuals whose disabilities led them to becoming certified in the first place. It is backward, it is not working, it is not going to work and all that was accomplished was creating lower-paid case managers. So you, the Dept. of Health, the Health Care Authority, whomever...fix it to accommodate the individuals you say you created the positions for or call it what you mean. That's my opinion. Thanks.

Jamie

A drawback under professionalism is, "Could change the core spirit of the Peer Counselor Program. Moving it to DOH might change it to a "medical model" rather than the current "recovery model"; and the two have very different philosophies"; this concern is valid and should be carefully considered. The medical model has not served the behavioral health

community well and has likely exacerbated behavioral health conditions. However, mainstream systemization of peer counseling could help reform the 'medical model' so behavioral health is a priority and treated with respect.

I would like peer counseling to be available in the IT field especially for agencies like DSHS. A large number of people who received services from DSHS in the past have come to work here including myself. This creates a uniquely difficult place to work. I've worked for DSHS Enterprise Technology for 5 years. This job is an uncomfortable mix of people with large egos (never having struggled in life) and people with little or no ego (having long-suffering and/or trauma in their past). In DSHS IT, many people do not know about or understand peer counseling. It is associated with psychosis and dismissed because people believe emotions and behavioral health don't belong at work (it's stigmatized even at DSHS).

Monica Santanicola

I recently received an email asking my opinion about possible changes to the Peer Counseling Program. I have been a peer counselor for over a year now and I am also a SUDPT (formerly CDPT). I was trained by doing the online course and then the 1-week in class program. I believe there should be no change in how to obtain the peer counselor certification. I do believe that continuing education should be required annually, but only in the form of online courses that have no charges. I also believe that once the course is completed and that you have obtained your certificate, the Department of Health should be involved for annual renewal. Since there is a qualification of personal experience regarding peer counseling, it is important to ensure the peer counselors are continuing their program of recovery. Background checks should have the same allowances as SUDP/T's.

I do believe in advanced training for peer support specialists to perform services in the areas of mental health, SUD, and forensic behavioral health; however, this should only be to assist in certain working environments. For example; working at inpatient settings for BH or SUD. Peer support specialists are vital in assisting counselors with the "extra's" but not doing their jobs that they have specifically been educated for. I work in a SUD inpatient facility and we do not have the time to go the extra mile when it comes to housing. This is a huge need. If we had peer specialists, they could help with that but would need advanced training on working with our specific cliental. They would need to know how to handle certain situations and behaviors.

It is my understanding that the reason peer support specialists have become in so much demand is the ability to obtain the agency-affiliated license and do some of the work a counselor cannot do to help with the client load. More and more people are now seeking treatment than in the past and we just do not have enough licensed staff to accommodate caseloads. This is not a reason though to make peer support specialists "just trained enough" to finish what the counselor cannot. What happens to pay for the licensed professional? Is there a

state grant that employers can use to have peer support specialists in their facilities? If a licensed counselor wants to become a SUDP, they have 5-years of college education. What would the requirement be for someone who is a peer support specialist with no college education, to start working in the SUD field? What is your development plan of "advanced training mean?"

I would like to see support for those that are in the SUD field like myself, have the opportunity to take advanced classes in the behavioral health field. This way we have the ability to be co-occurring counselors. If a LMP can take the one year course for SUDP and then only have to collect 500-1500 hours (instead of the 2500 I was required to get), I would think they have another way of training for people who have an associate degree but so many hours as a counselor to count towards an LMP license. This sounds crazy right? Well this is what I hear when someone is thinking about advanced training for a peer support specialist. The advanced training is to go back to college and get a degree than get a state certificate.

Brenda Thorson CPC, SUDPT

I question the intent of moving this licensure from where it is to the Department of Health. I feel that several large agencies and their powerful leaders in COO and CEO level positions have always resisted peers and their work. This is an example of listening to their protests that they "don't know how to supervise" peers and have refused to give them viable career development in their agencies.

I think this is the state caving to their issues and refusing to hold them accountable and delaying what peers deserve as professionals in the field.

I would rethink these implications and this seems like a bad idea that will suppress the spirit of peer support. I was at Peer Pathways Conference recently and a lot of people shared frustration with this idea. Where were you then to take comments from peers? Where have you been to take comments from peers? Do better.

Dennis Swennumson

I am writing to express my views on the proposal to bring peer counselor credentialing under the auspices of the Dept. of Health, and adding an advanced peer counselor credential. I am in support of both these proposals. I am currently an associate licensed mental health counselor with a Masters Degree in clinical mental health counselor and I work with a certified peer counselor, and before I had this job, I was a certified peer counselor myself for 2.5 years. I believe bringing the peer counselor certification under the umbrella of the DOH like the certifications of all the other mental health professionals the peer counselors work alongside would provide consistency and uniformity across the licensing and credentialing process for all

mental health professionals who work together, which is a positive development. I also believe it is a good idea to offer an advanced credential for peer counselors with advanced training and competencies, a credential I certainly would have liked to pursue while I was a peer counselor. Peer counselors, too, deserve an opportunity for professional advancement and growth for those interested in pursuing advanced competency in their profession.

Adrienne Delaney, MA, LMHCA, MHP, Certified Peer Counselor, Clinician

Comments Provided at Public Comment Meeting
September 24, 2019

Marcia Roi from Clark College discussed addiction culture, which requires a very different communication style than working with individuals with mental health disorders. She said their training needs to address the bias and stigma that accompanies addiction. She also discussed the confusion in the community regarding the various names for peers, such as peer navigator, recovery coach, and peer counselor. She said that using “peer” in the title is against the Americans with Disabilities Act (ADA) because it reveals someone’s recovery status. She likes the title recovery coach better. She told some stories about recovery coaches who had gone through the Connecticut Community for Addiction Recovery (CCAR) training who violated ethics and boundaries, one ending in a client death. She also said she has met recovery coaches who said they were state-certified because they had a certificate from the CCAR recovery coach training. She has taken this training and said it was not competency-based and everyone passed the examination. She said it was inadequate and should be done through community colleges, where students can receive credit for prior learning, it would be competency-based, and they could weed out the students who don’t deserve to graduate. She also supports the Certified Peer Counselor Program moving to DOH.²³

²³ Dr. Roi was talking about recovery coaches and the CCAR training, which are not the same as the Peer Counselor Certification Program. This training is not approved by HCA, nor accepted by Medicaid for reimbursement of peer services. HCA’s training is competency-based, the examination is done by a separate entity than the training, and not all students pass the examination.

Appendix B: Letter RE: Reimbursement



Memorandum

To: Sherry Thomas, Washington State Department of Health

From: Lonnie Johns-Brown, Washington State Office of the Insurance Commissioner

Date: September 19, 2019

Subject: Provider Credentials – Behavioral Health: Legislative Implementation Questions – Insurance Reimbursement

Thank you for asking the Office of the Insurance Commissioner (OIC) for input to support Department of Health (DOH)'s implementation of ESHB 1768 and 2SHB 1907. In order to be 'reimbursable' under insurance/health benefit plan coverage, the provider of the covered service must be licensed under title 18 or chapter 70.127 RCW, or be supervised by or the agent of such a licensee. RCW 48.43.005 (24) [definition of "provider"].

For the Medicaid program, we believe that any new credential would need to be included by Health Care Authority in the WAC 182-502-0002, which lists eligible provider types, but recommend you confirm this with the Health Care Authority. However, there isn't a comparable list of eligible provider types under the insurance code, and instead the more general "scope of practice under the license" determines whether the provider is eligible to provide a covered service. See, RCW 48.43.045, WAC 284-170-270.

Finally, depending on the taxonomy system used by the carrier or Medicaid program, the medical billing and payment system would need to recognize the classification of the provider in order to adjudicate and pay the claim.