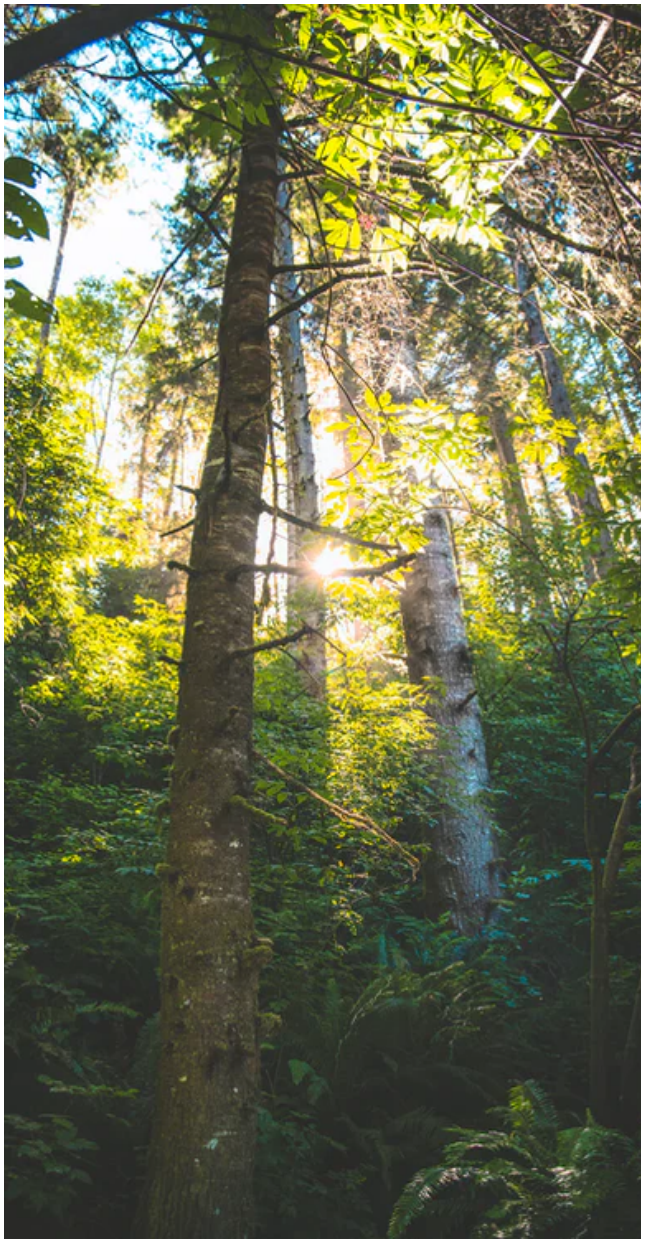

FLYING WITH OUR OWN WINGS: OREGON'S PEER-DELIVERED SERVICES WORKFORCE NEEDS ASSESSMENT REPORT

MHAO
MENTAL HEALTH & ADDICTION ASSOCIATION OF OREGON

Comagine Health

SEPTEMBER 2020

Report title: Flying with Our Own Wings: Oregon's Peer-Delivered Services Workforce Needs Assessment Report[1]

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Acknowledgments: We want to acknowledge all those who came before us, and their tireless advocacy and sacrifices in the name of the consumer/survivor/ex-patient movement. It is because of those who have walked before us and paved a path upon which we can walk alongside others, that peer-delivered services are what they are today in Oregon. We have a vibrant community, and strong ties to the movement's history. There are countless persons with lived experience whose work has positively impacted our ability to even be in such a place of privilege as to present this report.

To everyone working across the state in peer support, and all the members of the peer community: we see you, and we thank you.

Thank you to everyone who provided input on the design of this project, participated in our discussion groups, surveys, interviews, and helped outreach to make sure there was workforce representation from across the state. Your support made this project a success!

This project would not have been possible without the support of the Oregon Peer Delivered Services Coalition (OPDSCo), our Steering Committee, Advisory and Evaluation Committee, OHA Office of Equity and Inclusion, and Comagine Health.

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[1] "Flying with our own wings" is a play on the Oregon state motto: *Alis volat propriis* - She flies with her own wings.

Table of Contents

Note on how to read this report: This report is separated into several mini-reports: one for each of the primary data collection methods (discussion groups, peer-delivered services workforce survey, employer survey, and key informant interviews). Each mini-report has information about the participants who contributed their thoughts and feedback, as well as the findings and recommendations. The overall primary recommendations across data collection methods may be found in the executive summary. More details on each method, discussion, and additional findings are available in the appendix.

Highlighted and underlined green text includes a clickable link to resources. References are cited as footnotes throughout the document, to provide quick access to sources.

Executive Summary

The Oregon peer-delivered services workforce needs assessment was conducted by peer-run community-based leader Mental Health & Addiction Association of Oregon (MHAAO) and Oregon Peer Delivered Services Coalition (OPDSCo) in collaboration with the Oregon Health Authority's Office of Equity and Inclusion (OEI) and Injury and Violence Prevention Program (IVPP), and Comagine Health from spring 2019 – summer 2020.

Developed alongside members of the peer-delivered services workforce and peer community, this project utilized a community-based participatory research approach with a mixed-methods design.

Data Collection	Data Collection	Data Collection
Discussion groups with polling and open discussion	**Phone interviews with people delivering peer services**	**Workforce and employer online surveys**
Participants	**Participants**	**Participants**
152 **Peers and employers**	20 **Peers in direct service roles**	401 **Members of the peer workforce**
4 **Discussion groups**	8 **Peers in leadership roles**	49 **Employers**

36 of **36**
Oregon **counties represented** across the 3 data collection methods

The primary aims of this needs assessment were to:

1. Describe the **barriers, challenges**, and **successes** of the **peer-delivered services workforce** and its **employers** across Oregon
2. Better understand how to **support the workforce** and its employers, and **recognize any gaps** in current support strategies
3. **Identify sustainability strategies** for peer-delivered services, including ways in which reimbursement may be improved

The content of this needs assessment report reflects the many contributions of its participants across discussion groups, surveys, and interviews, in addition to the valuable feedback provided by stakeholders throughout the project period.

In line with the needs assessment findings and relevant literature on peer-delivered services, the following recommendations were developed for consideration by the Oregon Health Authority:

Systems Advocacy:

- **Advocate for adequate wages and growth opportunities within the peer workforce.** To maintain a healthy workforce, wages and other benefits should align with the job's high emotional demand and demonstrate appreciation for the required lived experience and challenging and skillful work that peer-delivered service workers provide. Opportunities for career pathways within the peer workforce are needed to retain and maintain a strong workforce, in addition to ensuring persons with lived experiences are reflected at all levels organizationally and integrated within service teams.
- **Encourage ongoing advocacy** to increase awareness and understanding of the role and value of peer delivered services. Share information with coordinated care organizations, communities, and organizations about the roles of peers to highlight their importance as integral members of care teams, and to decrease ambiguity about their roles. Provide leadership and advocacy training to peers to fully engage in discussions that impact the peer workforce – nothing about us, without us!
- **Strengthen existing guidelines around best practices for contracting with community-based organizations** to reduce confusion about peer roles and educate prospective funders and contract administrators about ways to contract with peer-delivered service providers and programs.

Diversity, Equity, and Inclusion:

- **Involve members of the peer-delivered services workforce** and persons with lived experience in the planning, design, and implementation of policies and practices that impact the peer workforce. Ensure input opportunities are accessible and timely, with communications given with as much advance notice as reasonably possible.
- **Provide funding opportunities to promote equity, inclusion, and diversity of the peer workforce,** through increased contracting with and funding opportunities for culturally- and linguistically -specific programs to increase service availability and diversity of the peer workforce. Prioritize funding for organizations led by and serving Black, Indigenous, and other communities of color. Provide technical assistance alongside newly awarded grants or contracts to support the success of the programs.
- **Support development of job descriptions that promote peer role fidelity and values.** Provide peer-directed technical assistance and examples of peer-delivered services job descriptions that maintain role fidelity. Ensure job descriptions do not include responsibilities and duties that would result in dual-relationships (e.g. role is part-peer support specialist and part-case manager). Requiring a personal reliable vehicle creates barriers that may impact workforce members, especially communities of color that may have less access to a vehicle due to racism, wealth and income disparities, and racially discriminatory pricing practices.

Supervision:

- **Clarify and support standards around peer-delivered service supervision.** Include budget lines for peer supervision within grants, contracts, and other funding opportunities. Widely distribute existing peer supervision standards, like the substance use disorder peer

supervision competency document developed by MHACBO and OHA's drafted peer support supervision recommendations. On the OHA THW Registry, include a classification for peer supervisors that is publicly available and easily searchable. Provide foundational peer supervision training to support the development of new supervisors, especially in rural or frontier areas where supervision is not currently available.

- **Promote co-supervision as a best practice,** ensuring that all peer-delivered service workers have access to peer supervisors who are familiar with the role and scope of peer-delivered service positions, and themselves have lived experience. Require co-supervision (or direct supervision by a peer) for OHA contracts and grants.
- **Require organizations to have adequate peer supervision models** and support organizations in training internal supervisors or contracting with peer supervisors who are experienced in understanding the role and scope of peer-delivered service positions. Ensure contract and grant funding is sufficient to cover increased costs related to supervision.

Training and Certification:

- **Support individuals in accessing peer certification through the Oregon Health Authority**, and provide technical assistance on navigating background check challenges. Provide clear and transparent communications about certification processing timelines.
- **Support certification and training standards**, which align with peer-delivered services models of support and collaboration, enhance fidelity, and streamline certification processes while ensuring candidates have the lived experience required for this work. Revisit stringent criminal background check standards, which can reduce the workforce and limit job opportunities for qualified candidates. People from underrepresented communities in the peer workforce may have disproportionate rates of arrests, convictions, and incarcerations leading to lack of diversity in the workforce. Increase training availability – and parity of type (e.g. mental health, family, youth, addictions) –in areas where training is not yet provided.
- **Support increased access to continuing education for peer-delivered service providers,** including development of culturally-and linguistically-specific peer certification trainings and continuing education opportunities, to decrease barriers to access to certification and workforce entry. Support training delivery in rural and frontier areas of the state, as well as in the 28 counties that do not currently have state-approved certification training programs.

Workforce Sustainability:

- **Develop ways to address compassion fatigue, vicarious trauma, and burnout**, which lead to high rates of turnover. Require organizations to have adequate supervision models and encourage peer connections across the state, including building on current support models within the peer community, such as Peer Support for Peer Support Specialists and the Peerpocalypse Conference organized by MHAAO, PeerGalaxy peer support directory, and the MetroPlus Association of Addiction Peer Professionals (MAAPPs) monthly meetings at which peers network with each other, learn from guest speakers, and share resources about ways to advocate locally and at the state-level. Improved access to peer workforce connection and networking opportunities can address feelings of pressure related to being the "only peer" within an agency and promote self-care and development through positive support opportunities.

Funding:

- **Provide technical assistance opportunities on accessing public funding streams**, to increase familiarity with funding options available to employers specific to peer-delivered services. Support connections between coordinated care organizations, OHA, and peer programs, with technical assistance provided to all parties as needed.
- **Increase funding opportunities available for peer-delivered services programs**, and ensure sufficient funds to cover living wages and benefits for peer staff, peer supervision, outreach and engagement, and travel time through reimbursement pathways that allow for fidelity to peer scope of practice. Increase contract clarity and transparency, and simplify reporting requirements to ensure fidelity to peer model. Support peer-centric documentation standards. Adequate funding increases financial stability of organizations, which was cited as a barrier to hiring and retaining culturally- and linguistically-specific peer-delivered service providers, in addition to providing competitive wages and benefits.
- **Address insufficient funding opportunities for peer-run programs and services** to create sustainable funding opportunities that align with services being delivered, and promote diversity, equity, and inclusion. Model transparency and provide technical assistance to diverse programs and organizations to access funding resources. Prioritize funding for organizations led by and serving Black, Indigenous, and other communities of color, in addition to persons with lived experience. Provide opportunities for the peer workforce to share input and impact policy and funding opportunities.
- **Address inadequate reimbursement rates and inaccurate coding for peer services** to create sustainable funding opportunities that align with services being delivered.

The results found within this report indicate a clear need for additional strategies to promote and sustain the Oregon peer-delivered services workforce at a critical juncture in its history as peer services experience statewide growth and expansion.

"My favorite part of my job is **using my lived experience** to **make a difference** in **others' lives**."

Comagine Health | MHAO Mental Health & Addiction Association of Oregon | Oregon Health Authority

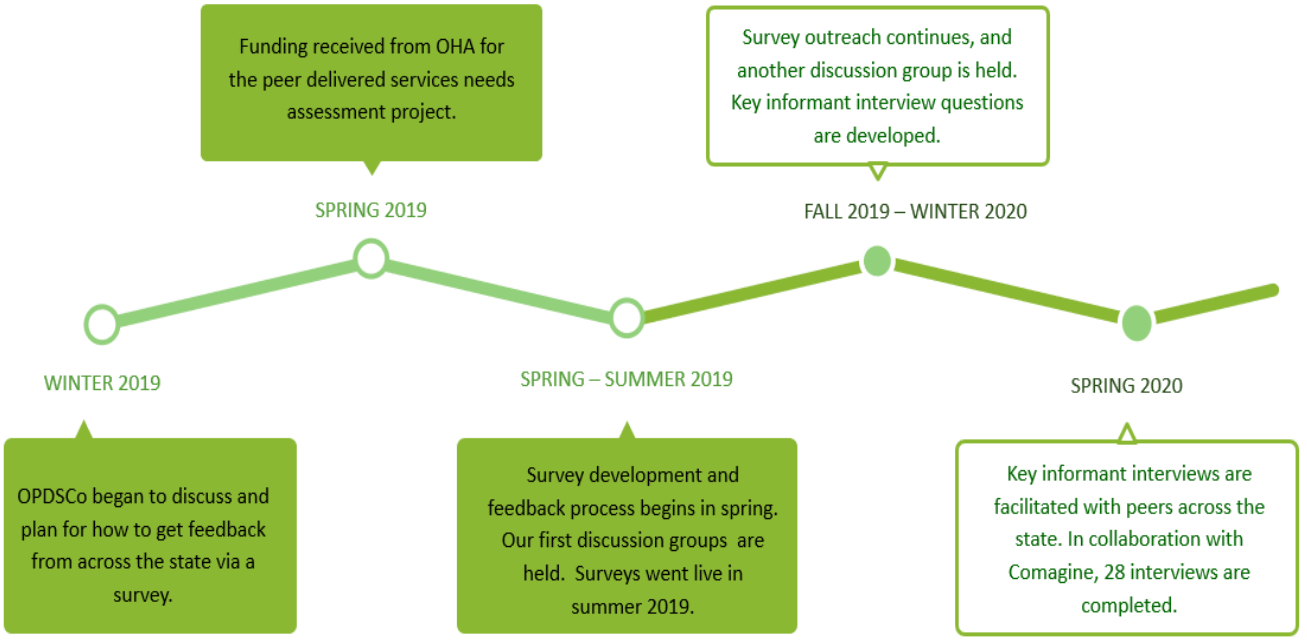
Background

The Oregon peer-delivered services workforce needs assessment was conducted by Mental Health & Addiction Association of Oregon (MHAAO) and Oregon Peer Delivered Services Coalition (OPDSCo) in collaboration with the Oregon Health Authority's Office of Equity and Inclusion (OEI) and Injury and Violence Prevention Program (IVPP), and Comagine Health from spring 2019 – summer 2020.

The Oregon Peer Delivered Services Coalition (OPDSCo) is a statewide consumer network focused on workforce development for peers across the state, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) from 2016 – 2019 as a program of MHAAO. While funded, OPDSCo was led by a Steering Committee composed of peer leaders and advocates from across Oregon. Our focus is to bring together individuals and agencies vested in the successful delivery of peer practices and the advancement of the peer workforce statewide. Through OPDSCo's work and feedback from peers and stakeholders across Oregon, the need for a statewide peer workforce needs assessment was identified.

The organization through which OPDSCo is housed, Mental Health & Addiction Association of Oregon, is a peer-run, community-based nonprofit that offers peer-delivered services, workforce development support, peer certification training, and technical assistance to peers and employers. Through support from OHA's OEI and IVPP and Comagine Health, MHAAO and OPDSCo have conducted a statewide peer workforce needs assessment.

Timeline of statewide peer-delivered services needs assessment



A brief history of peer-delivered services

Although forms of peer support have been occurring in Indigenous communities through storytelling, talking circles, and many other cultural practices since time immemorial, the first recorded instance of peer support occurred at the end of the 18th century in France, in a 1793 letter from Jean Baptiste Pussin to Philippe Pinel describing the benefits and practice of employing former "mental patients" in the Paris hospital at which Pussin was superintendent.[2]

"As much as possible, all servants are chosen from the category of mental patients. They are at any rate better suited to this demanding work because they are usually more gentle, honest, and humane." **— Jean Baptiste Pussin, in a 1793 letter to Philippe Pinel, advocate of moral treatment**

It was not until almost 200 years later that peer support service delivery was first referenced in literature, in an article published in 1991.[3] Prior to the 1990s, various paraprofessional or community-based supports had been mentioned and demonstrated good effect, like the lay counseling described by Robert Carkhuff and Charles Truax in 1965. Carkhuff discovered that nonprofessional lay helpers had equivalent to or higher levels of empathy, respect, genuineness, concreteness, and self-disclosure when compared to clinical practitioners. While Carkhuff's model of lay counseling did not require lived experience, it has similarities with peer support roles today; he describes how the role of the lay person "often tries only to stay with and 'be with' the client."[4]

Following the success of Carkhuff and Truax in the 1960s, community mental health professionals began to advocate for the integration of peers into primary care settings. It was in 1967 that Emory Cowen first proposed a model of community mental health care that mandated the employment of "nonprofessional peers in the development, implementation, and evaluation of community interventions."[5] About 10 years later in Denver, Colorado, the first peers were trained to work for the mental health system as professionals, as "Consumer Case Manager Aides". These peer providers – including movement activist Pat Risser –provided Medicaid-billable services under a state option waiver.

Peer support for addictions recovery has a long history in mutual-aid and peer-based recovery support groups, offered in lieu of or as a complement to professional health services.[6] William White (2004) identifies the rich history of recovery mutual aid societies, "spanning from 18th and 19th century Native

[2] Davidson, L., & Guy, K. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World psychiatry*, *11*(2), 123-128.
[3] Sherman, P. S., & Porter, R. (1991). Mental health consumers as case management aides. *Psychiatric Services*, *42*(5), 494-498. as cited in Davidson et al (2012)
[4] Carkhuff, R. R. (1968). Lay mental health counseling: Prospects and problems. *Journal of individual psychology*, *24*(1), 88-93.
[5] Cowen, E.L., Gardner, E.A., and Zax, M. (1967). Emergent approaches to mental health problems. New York: Appleton Century-Croft as cited in Tang, P. (2013, June 07). A Brief History of Peer Support: Origins [Web log post]. Retrieved September 01, 2020, from http://peersforprogress.org/pfp_blog/a-brief-history-of-peer-support-origins/
[6] Blash, L., Chan, K., & Chapman, S. (2015). The peer provider workforce in behavioral health: A landscape analysis. *San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care*.

American 'recovery circles' (abstinence-based healing and religious/cultural revitalization movements)" and the Washingtonians in the 1840s to Alcoholics Anonymous (AA) (1935), Narcotics Anonymous (1953), and the more recent Wellbriety Movement and faith-based recovery ministries.[7]

Peer support work has only more recently become a more formalized field and career, but peer support is built on a passionate history of mutual aid and community. It is this most recent form of peer support upon which our statewide needs assessment has focused.

Historically, the basis for peer-delivered services can be found in mutual support groups – where participants received empathy and support from others with similar life experiences—as the first peer-based services that were offered alongside clinical mental health services**.** [8]

The most well-known origins of peer support are tied to the consumer/survivor/ex-patient movement that arose out of the civil rights movements of the late 1960s and early 1970s. In Oregon in 1970 the Insane Liberation Front was founded by Howie the Harp, Dorothy Weiner, and Tom Wittick, typically cited as the first consumer-run rights group for mental health consumers.[9] In Portland in 1999, the first National Summit of Mental Health Consumers and Survivors was organized by the National Mental Health Consumers' Self-Help Clearinghouse with the help of the Oregon Office of Consumer Technical Assistance, and co-sponsored by consumer/survivor groups from around the country.[10] It was also in 1999 that the Supreme Court ruled in Olmstead v. L.C., 527 U.S. 581, that under the Americans with Disabilities Act passed 10 years earlier, undue institutionalization qualifies as discrimination by reason of disability, including people with a "mental disability."[9]

More recently in 2007, the Centers for Medicare & Medicaid Services (CMS) recognized peer support services as an important and evidence-based model of care for mental health. CMS approved coverage for the provision of peer services, and tasked states to develop the training and certification requirements.[11]

[7] White, W. (2004). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC. Accessed from https://www.williamwhitepapers.com/pr/2004PeerRecoverySupportServices.pdf.

[8] Chinman, M., Young, A. S., Hassell, J., & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research*, *33*(2), 176.

[9] Chamberlin, J. (1990). "The Ex-Patients' Movement: Where We've Been and Where We're Going," *Journal of Mind and Behavior 11* , no. 3: 323 –336

[10] Movement history of the consumer/client/survivor/ex-patient/ex-inmate/user community (n.d.), accessed from http://www.ndcfn.org/movement-history-of-the-consumer-client-survivor-ex-patient-ex-inmate-user-community-timeline.html

[11] State Medicaid Director Letter, Peer Support Services (2007). SMDL 07-011. Baltimore, Centers for Medicare and Medicaid Services. Available at downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf. Accessed August 23, 2020.

THW Commission

The Oregon Health Authority's Traditional Health Worker (THW) Commission – established in 2013 following legislative bill HB 3407 promotes the role, engagement, and utilization of the traditional health workforce, which includes peer support and peer wellness specialists, community health workers, personal health navigators, and doulas. The Commission advises and makes recommendations to the Oregon Health Authority "on the development, implementation, and sustainability of the Traditional Health Worker program and ensures the program remains responsive to consumer and community health needs."[11]

Training Evaluation and Metrics Scoring Committee

The commission subcommittee utilizes a rubric for evaluating training programs that includes an organizational assessment and required curriculum topics review. Furthermore, TEMPS establishes the metrics, standards, and guidance for continuing education requirements for all traditional health workers who wish to be eligible to renew their THW certification with the Oregon Health Authority.

Peer-delivered Services in Oregon: A snapshot

Following the CMS directive, the Commission's Training, Evaluation, Metrics, & Program Scoring (TEMPS) subcommittee was tasked with developing the metrics, standards, and guidance needed to review and approve THW training program applications from organizations interested in offering state-approved THW certification training programs. To provide Medicaid billable services, peer-delivered services workers must become certified through the Oregon Health Authority as a traditional health worker.

Currently, eight of Oregon's 36 counties offer state-approved peer certification training programs.

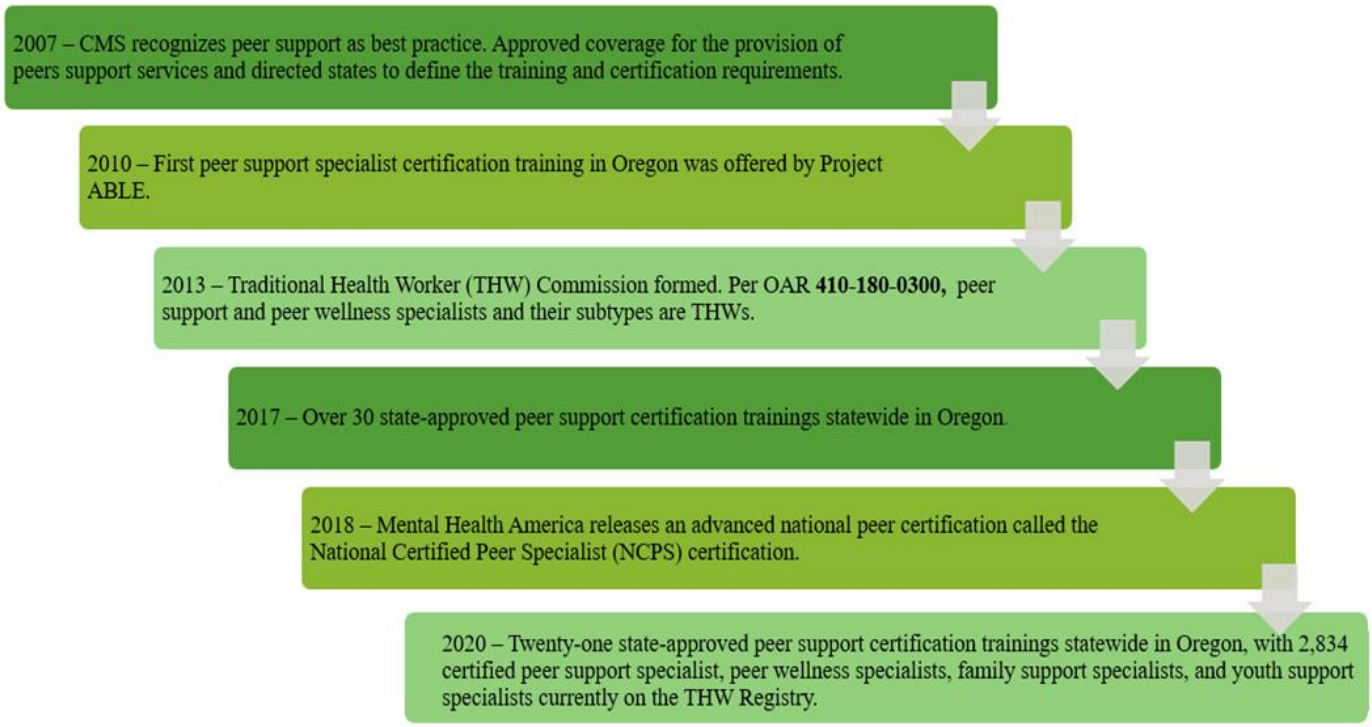
In "The State of Mental Health in America 2020", Oregon ranks fiftieth overall, with a higher ranking indicating higher prevalence of mental health challenges and lower rates of access to care. That's second-to-last nationally.

Peer credentialing

Through **OHA**, peer workers can become state-approved as **traditional health workers** (THWs). There are 5 different types of THW as defined by the OHA. Two of the 5 types are specific to the peer workforce: peer support specialist (PSS) and peer wellness specialist (PWS). The PWS receives 40 additional hours of training on whole-health related topics like health across the lifespan, disease processes, health literacy and systems, and working on interdisciplinary teams. Both worker types have numerous sub-types in line with the lived experience of the PSS or PWS (e.g. mental health, addictions, family support, youth). The PSS and PWS have two specific specialties of family support specialist and youth support specialist, within which both may work in mental health, addiction, and other peer-related capacities related to their lived experience.

Mental Health & Addiction Certification Board of Oregon (MHACBO) also offers several peer certifications for individuals in addiction recovery: the certified recovery mentor (CRM), peer recovery counselor (PRC), and certified gambling recovery mentor (CGRM). While the background check and application process differ from OHA's, MHACBO applicants must also take a state-approved training.

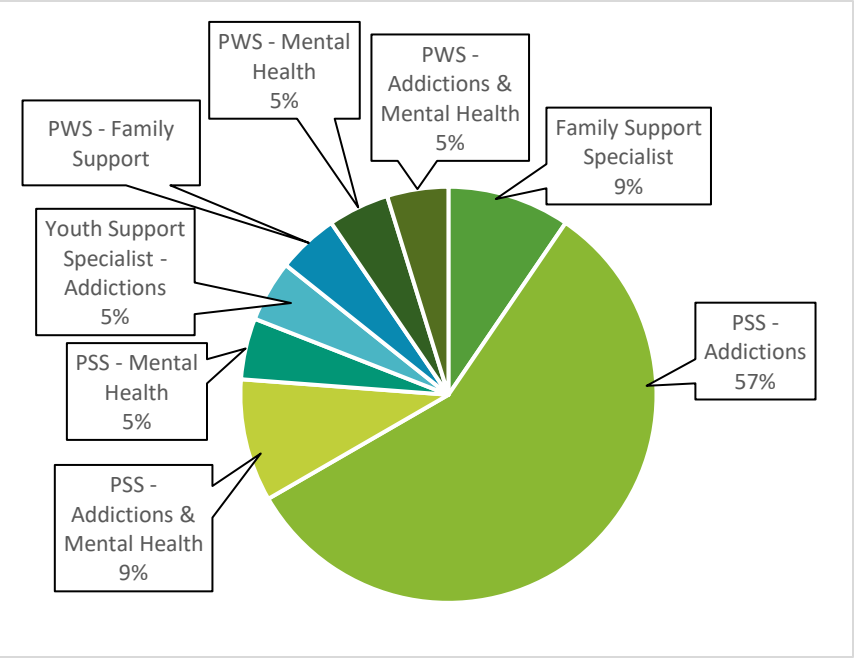
Abridged Timeline of Peer Support Certification in Oregon

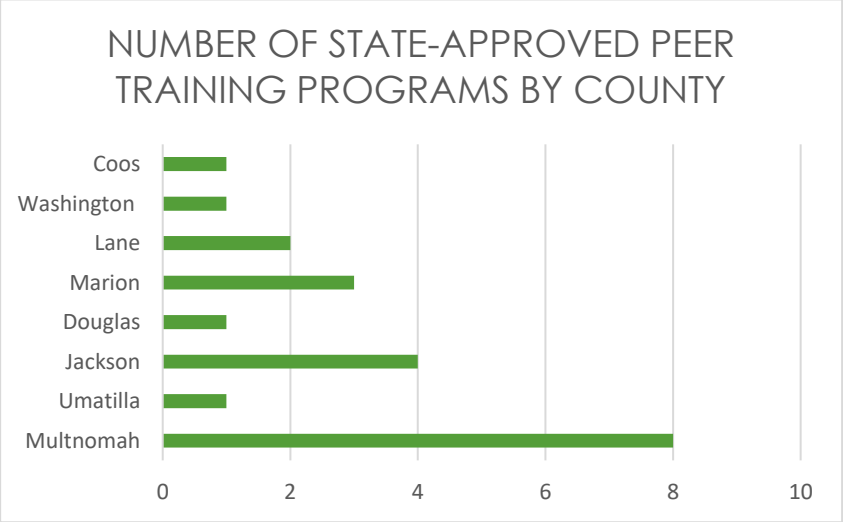


"Peer support is a system of **giving and receiving help** founded on key principles of **respect**, **shared responsibility**, and **mutual agreement** on what is helpful. Peer support is **not based on psychiatric models** and diagnostic criteria. It is about **understanding another**'s situation empathetically through the **shared experience** of emotional and psychological pain."

-Shery Mead, founder of Intentional Peer Support

Broken down by training type, the disparity between numbers of trainings available by peer worker type becomes clear. A majority of the 21 state-approved training programs are for individuals with lived experience of addiction(s).[12] The chart shows that a total of 76% current state-approved certification training programs are offered for individuals to pursue addictions certification (of those, 14% include both addictions and mental health certification options within one training). Ten percent of programs are dedicated to mental health specializations alone, and 14% are available for family support specialists. There is only one currently approved youth support specialist training in Oregon.

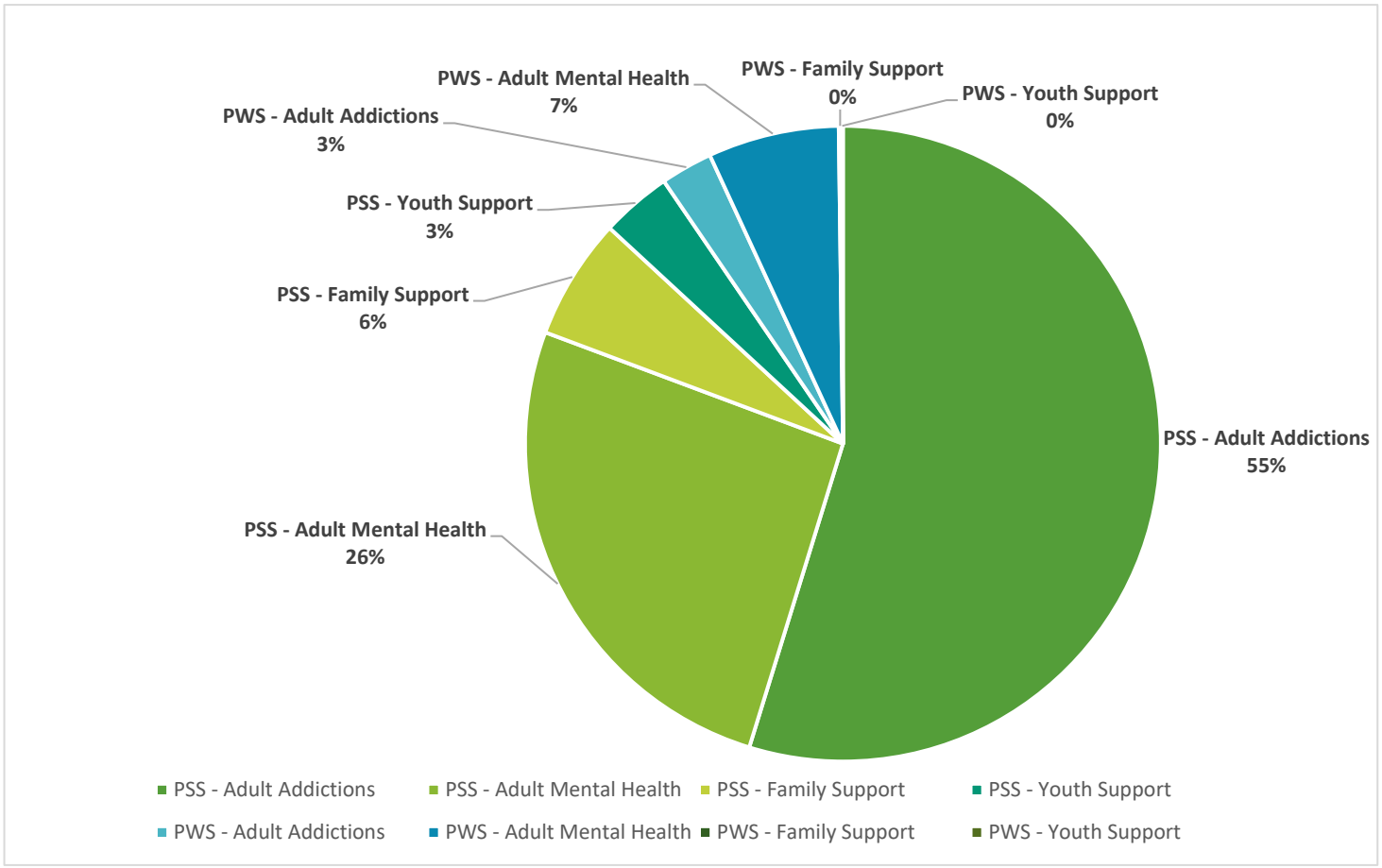




This graph depicts the number of Oregon Health Authority-approved peer certification training programs available across the state. Multnomah county – Oregon's most populous and home to its largest city of Portland – has double the amount of trainings (8) when compared with the next highest number of training offerings in Jackson county (4). Only four Oregon counties have more than one state-approved certification training program: Multnomah, Jackson, Lane, and Marion counties. The remaining trainings are distributed evenly across Coos, Washington, Douglas, and Umatilla counties, all at one each.

[12] Data to create these visualizations were pulled from OHA's publicly available lists of state-approved traditional health worker certification training programs – accessed and current as of September 9, 2020 at https://www.oregon.gov/oha/OEI/Pages/THW-OHA-Approved-Training-CEU.

ACTIVELY CERTIFIED PEER TRADITIONAL HEALTH WORKERS ON THE OHA REGISTRY SEPTEMBER 2020



CERTIFICATION TYPE	TOTAL	PERCENT OF WORKFORCE TOTAL
PEER SUPPORT SPECIALISTS		
Peer Support Specialist - Adult Addictions	1552	55%
Peer Support Specialist - Adult Mental Health	735	26%
Peer Support Specialist - Family Support Specialist	175	6%
Peer Support Specialist - Youth Support Specialist	102	3%
PEER WELLNESS SPECIALISTS		
Peer Wellness Specialist - Adult Addictions	75	3%
Peer Wellness Specialist - Adult Mental Health	189	7%
Peer Wellness Specialist - Family Support Specialist	4	0%
Peer Wellness Specialist - Youth Support Specialist	2	0%
TOTAL CERTIFIED	**2,834**	**100%**

Concise overview of existing peer support literature

Peer support has research-based positive outcomes, in addition to countless stories of recovery from those who have worked within the field or have been recipients of peer-delivered services themselves. Peer-based services are included on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP)[i][13].

The beauty of peer support can be found in its willingness to "meet people where they are at", wherever that may be. This flexibility and variation of peer support delivery and programs can make isolating variables for evaluation difficult, although there are many advantages to a person-directed, individualized approach in practice. With respect to longitudinal research, some aspects of peer support, like coaching and mentoring, have existing literature attesting to their benefits.

A systematic review of peer-delivered services literature spanning two decades revealed that several studies have found peer-delivered services – compared to what were termed professional services – to have better outcomes across several indicators, including **higher service use rates**, **reduced rates of hospitalization,** and **improved senses of hope** and **self-esteem**.[14]

In another review (Reif et al., 2014) that was part of the Assessing the Evidence Base (AEB) series sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), studies that met minimum criteria for moderate or greater evidence of effectiveness were examined to demonstrate impacts of peer-delivered services. The evaluated studies included randomized control trials, quasi-experimental studies, pre vs. post research, and research reviews. The results from the reviewed studies demonstrated:

- **reduced relapse rates**
- **increased treatment retention**
- **improved relationships** with treatment providers and social supports
- **increased satisfaction** with overall treatment

Another research analysis – also a part of the Assessing the Evidence Base series - reviewed the level of evidence and effectiveness of peer support services delivered by individuals in recovery, and concluded that while peer support services have "demonstrated many notable outcomes," studies that "better differentiate the contributions of the peer role and are conducted with greater specificity, consistency, and rigor would strengthen the evidence." [15] Given the newness of peer support in terms of being a unique and more formalized discipline, more robust research is being developed as the recognition of peer-delivered services grows.

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13 In early 2018, federal health officials indefinitely suspended the NREPP.

14 Rogers, E. S., Kash-MacDonald, M., & Brucker, D. (2009). Systematic review of peer delivered services literature 1989 – 2009. Boston: Boston University, Sargent College, Center for Psychiatric Rehabilitation, Accessed from http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/peer-delivered-services.

[15]Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatric Services*, *65*(4), 429-441.

Methods

This project utilized a community-based participatory research approach across three primary data collection methods: discussion groups, key informant interviews, and online peer workforce and employer surveys. Data was also collected and analyzed from publicly available sources, such as census data and information from the Oregon Health Authority traditional health worker registry and sites. Members of the peer workforce, Oregon Peer Delivered Services Coalition Advisory and Evaluation Committee and Steering Committee, and the state Office of Equity and Inclusion provided feedback regarding project design and implementation. Both peer workforce and employer surveys were adapted from a template provided by the Office of Equity and Inclusion, with feedback provided by stakeholders – including members and employers of the peer workforce, health authority staff, and peer advocates across urban, rural, and frontier Oregon. Researchers with Comagine Health also offered guidance in the development of the key informant interview guide and implementation, working alongside MHAAO as interviews were collaboratively conducted. Input from the Oregon peer community was requested on an ongoing basis and incorporated into the project and its design.

A mixed methods design was employed to capture both the richness and value of the stories from the peer workforce community, in addition to quantitative data collection through online surveys and polling segments during discussion groups. Moreover, data was also collected from the Oregon Health Authority Traditional Health Worker registry, an online database administered by the Office of Equity and Inclusion that includes all persons registered as traditional health workers in Oregon as well as their worker type, county, and brief demographic information. [ii] Please see appendix for more details on methodology.

Peer-Delivered Services

Discussion groups with peer-delivered services workers, leaders, and employers in Oregon

Data Collection

Discussion groups with polling and open discussion

Participants

- 152 Peers and employers
- 4 Discussion groups
- 20 Counties represented

The Oregon Peer Delivered Services Coalition's annual summit took place in spring 2019 in Pendleton. The no-cost day-long event brought together 60 peers, leaders, and employers from all parts of the state, with primary representation occurring from eastern Oregon, Portland metropolitan area, mid-Willamette Valley, and southern/Oregon Coast. Summit discussions informed the following discussion groups' design.

Discussion group format

To promote accessibility and acknowledge different comfort levels with public speaking, multiple formats of providing feedback were offered to participants:

1: Anonymous virtual polling on the four main areas of professional development, future of peer services, accomplishments, and challenges and barriers;

2: Facilitated open group discussion on four key areas relevant to the workforce;

3: Invitation to share input with discussion group facilitators, either privately in-person or via email or phone.

From spring 2019 – summer 2020, discussion groups took place in eastern Oregon, the Willamette Valley, southern Oregon, and virtually in response to the COVID-19 pandemic. All those who engaged in the discussion groups identified as persons with lived experience who were currently (or had previously been) working in a peer support role, or were making efforts to become employed as a peer. Some of the participants were in positions of leadership and/or employers of peer-delivered services workers. This report summarizes the findings from the discussion groups.

Participants shared their experiences across four main categories.

Four main questions guided the discussions:

- What professional development/support would you like to receive in your role as a peer?
- What barriers or challenges have you encountered related to fulfilling your work as a peer?
- What have you accomplished through your peer support work?
- What would you like to see in the future for the field of peer delivered services?

"Nothing about us, without us!"

FINDINGS

PROFESSIONAL DEVELOPMENT AND WORKFORCE SUPPORT NEEDS

When polled regarding the professional development or support they would like to receive in their roles as members of the peer workforce, there were minor differences between the two most commonly selected responses: continuing education (20%) followed by effective advocacy for a living wage (19%).

Across discussion groups, multiple themes emerged related to professional development and support needs, or what peer workers need to do their best peer support.

SYSTEM EDUCATION AND ADVOCACY

"The workforce is so new and people don't understand what it is."

The need for system education about peer-delivered services continuously came up in our discussion groups. Peer-delivered service workers want to be better understood by the various systems they work within (e.g. behavioral health, corrections, healthcare, etc.), and also want to be better educated themselves on system navigation. Educating others outside of the peer profession was described as a challenge.

Some participants mentioned the burden and pressure of having to educate systems, organization leaders, and their own supervisors on what peer delivered services are and what they look like. In some cases, this was brought up as interfering with their ability to accomplish their peer support role – given that most of their time needed to be dedicated to tasks outside of their job description, like program development and the education of others. Many mentioned concerns about cooptation of the peer role and the importance of using peer-based, non-clinical language.

Several themes were identified across discussion groups related to system education and advocacy. Peer workers would like to see the following:

- Support to inform providers (e.g. BH, MH, SUD, physical health, CBOs) the value of peer-delivered services, how to maintain fidelity, and what peer support looks like in practice
- Increased community awareness
- Support to teach providers ways to utilize/contract with peer-run organizations
- Leadership training in advocacy (both individual and systemic)
- Leadership academy available for peer workers

Specific to protections while engaging in advocacy, a few items were raised:

"They [employer] don't know what it should look like. It can be exhausting."

"We struggle to be taken seriously as a profession."

"Management limits our voice."

- Peer job descriptions need to include systems change protections while helping shift culture within organization(s) and system(s)
- Supervisor support/protection in fulfilling peer role - which is not to convince people to follow their treatment plan, and may - at times –
  be counter to what clinical teams view as best
- Support to have knowledge of whistleblower protections

Organizational education and awareness raising

Organizationally, multiple participants reported that upper management does not understand the peer support role. Also, many peer workers want to understand how the upper management within their own organization functions. Requesting team building and unity training, peer-delivered services workers would like to see "gaps bridged through companies". Overall, participants wanted more education on peer support to be readily available – broadly and within agencies.

A lack of understanding of peer-delivered services can result in an underutilization of skills to support those receiving services, and ultimately in peer support not being fully used. In addition to not being understood in their peer roles, participants shared that the word "stigma" should be replaced with bias, discrimination, prejudice, or oppression to highlight what stigma is and how it manifests.

Recognition of profession

Peer workers often reported seeking to be recognized for their profession and the valuable work they do. Participants suggested multiple ways to demonstrate recognition, such as:

- Honor specialized knowledge/practices within the peer-delivered services workforce
- Recognize peer-delivered services workers as a non-clinical profession
- Receive recognition by clinicians
- Provide clinical support and "voice at the table"
- Encourage community support
  - Raise awareness of the role and value of peer workers
  - Provide community opportunities to build connections and deepen understanding of diverse lived experiences in non-judgmental forums
- Encourage communication with and support from community partners; valuing peer partners as important, skilled team members and service providers
- Considered an equal on all teams is desired

Participants mentioned a lack of respect for the peer workforce, and feeling like "management limits our voice."

Participants shared the importance of having an ethics board available through a professional peer workforce organization, similar to how Mental Health & Addiction Certification Board of Oregon has an ethics board for review of potential ethics violations, in addition to providing technical assistance around ethics for individuals certified through that body.

Several also mentioned hopes for a membership-funded organization for peer/consumer paid advocacy roles, in addition to an interagency peer support professional association.

Role clarification

A "gray area" as to what peers are allowed to do and not do can result in role confusion and even result in anxiety or fear. In every discussion group, the importance of role clarification – what we do and do not do as peer workers – was emphasized. Consistency in role development, and ensuring access to trainings (specifically on documentation, upper management training on peer roles, and training in clinical settings (on the recovery model for peer support) were specifically mentioned as part of role clarification**.** Participants reported wanting more information on the differences between the various subtypes of peer-delivered services worker (e.g. mental health, youth, family, addictions), in addition to training and resources on the scope of practices. Participants also mentioned that clear and accurate job descriptions were another challenge.

Finally, participants impressed the need for fidelity to peer support, especially when working within medical models or systems where peer support is not well understood or recognized. Generally, there is a lack of understanding that peer roles were born out of the consumer/survivor/ex-patient movement.

Organizational support

> "[The organization] goes above and beyond when it comes to training, anything needed."

Some participants highlighted how supportive their organization was, and how that enabled them to focus on providing their best peer support. Many participants said connection opportunities like monthly group check-ins were helpful. Participants also expressed wanting more networking opportunities for members of peer workforce (particularly occurring outside of their workplace and unaffiliated with employers). Participants reported wanting ways to connect with one another as members of Oregon's peer delivered services workforce. Participants also described a need for more organization support when people they serve are in crisis or die.

Supervision

Members of the peer support workforce reported mixed experiences with their supervision. Negative experiences described included:

- Not having a supervisor or access to supervision
- Being responsible for doing part of a supervisor's job (e.g. program development) due to a lack of understanding of peer delivered services or its implementation
- No supervision structures in place
- Feeling "forced" to receive supervision from a person who is not a peer
- Not feeling heard, respected, or understood by management

Positive experiences related to supervision included:

- Having both a clinical and direct supervisor

- "Growing through supervision" with a peer supervisor
- Feeling supported through peer supervision

Training and Certification

"People are becoming certified who don't have enough recovery time."

Participants gave feedback that the credentialing system needs to re-assessed due to "high numbers" of individuals who are becoming certified even when not meeting the qualifications and requirements to become certified as a peer-delivered services provider. Several reasons were provided for this:

- High demand for peer workers and a small supply of rural peer workers
- Lack of local training can impact numbers of non-qualified individuals applying to become grandparented into certification, without meeting grandparenting requirements
- Lack of understanding about certification requirements and lived experience qualifications

Participants from outside the Portland metropolitan area mentioned that local training is not available. Cost of foundational training and continuing education units were also cited as a barrier for participants regardless of location. Further, participants reported that the background check process needs to be simplified and be faster, sharing how background checks could take weeks or months and delay the certification process.

WORKFORCE BARRIERS AND CHALLENGES

Participants reported that the high volume of required documentation was a barrier to peer work. Participants suggested collaborative documentation as a way to stay true to peer roles while still meeting organizational expectations around documentation and billing. Most current documentation processes require a more clinical lens, counter the philosophy of peer support.

Collaborative documentation:

Process by which the person writing the note collaborates with the person receiving services whom the note is about. Some of the benefits include:

- Increased transparency
- More peer-centered notes
- Improved accuracy
- Time-saving

Multiple participants mentioned how difficult it was to be the "only peer," and sometimes even acting as their own supervisor with no supervisory support in place. A lack of support and being the "only advocate" creates "big pressure" that is challenging for peer workers.

Participants also reported that avoiding dual relationships was challenging, especially when asked to fulfill multiple roles within the workplace. Organizations unfamiliar with peer services may develop a peer support job description that is part-peer support and part another role, commonly case manager. The worker then becomes responsible for fulfilling all aspects of their role, including those responsibilities which are not in line with peer-delivered service role fidelity.

Participants described difficulty in finding clear and transparent program criteria for people receiving services, and shared that "cherry-picking" occurs with some community members being declined from services while others "who have interpersonal relationships with organizational staff are welcomed".

Culturally and Linguistically-Specific Services

Another key finding from the discussion groups was the lack of culturally-specific peers available within the workforce, and a general lack of understanding of how to support those receiving services who are a part of a cultural group of which the peer worker does not identify. Most peer-delivered services are available only in English. Multiple participants noted a lack of diversity within the peer workforce, and identified the need to hire a more diverse peer support workforce, including youth and young adults.

One discussion group expressed the hope for a more non-judgmental, diverse, and tolerant peer workforce in the future.

Transportation was an additional barrier identified through the discussion groups. Specifically, how peer-delivered service providers may be required to have a driver's license, own their own reliable transportation, and be comfortable driving others to be hired into some agencies.

SUSTAINABILITY

"The #1 thing I'd change about peer services in Oregon is payment methods."

"Because we're **not underneath a clinical structure**, we're **not able to get paid** the money that will **support our programs**."

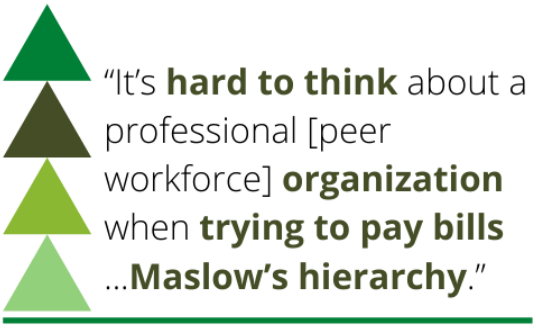
Funding and Payment Methods

Participants frequently expressed the significance and scarcity of funding. Participants described a critical need for more funding for and contracting with peer-run programs and organizations. Participants described the current payment models as frustrating because of the "red tape" that makes it difficult to be reimbursed for peer services, through confusing and insufficient payment pathways that limit how and where peer-delivered services may be provided (e.g. in treatment settings, as an approved part of a treatment plan, and/or under a clinical structure). Leaders and employers defined challenges in finding sufficient pathways for funding, and feeling undervalued despite doing work that impacts social determinants of health and other outcomes key to Medicaid standards.

Several participants raised concerns about misuse of funds that could occur due to a lack of quality assurance and inconsistency in contracting standards for peer-delivered services.

Wages

Participants frequently referenced pay as a barrier to peer work. Participants requested effective advocacy for a living wage for their roles and recognition of the level of skill and lived experience necessary to do this work.



Career Pathways

Overwhelmingly, participants reported a need for the following:

- Opportunity for growth and ability to use the peer certification for which they were trained
- Career ladder pathways and opportunities for promotion
- Peer support/mentors in management/admin/director roles – at various levels across the organizations
- Increased mobility within peer-run organizations

ACCOMPLISHMENTS

Participants reported numerous successes and accomplishments achieved through their work in peer delivered services. Key categories that were described included inclusion, support, recovery, connections, improved access to services, changed lives, awareness raising, valuing choice, and empowerment.

One of unique benefits of peer support is that of mutuality. Responding to the question of what accomplishments they had experienced in their peer support work, one attendee highlighted the mutuality present within peer support, sharing that they "transformed lives through promoting self-determination and those empowered lives transform systems as well."

Many participants also mentioned personal benefits as a result of their work: increased awareness of other cultural perspectives, opportunities to lead by example, improved feelings of acceptance or being "normalized", and discovering community and connection.

Conclusion and Recommendations

Participants shared varied experiences as members of the peer-delivered services workforce, leaders, and employers across topics designed to better understand their needs, challenges, and successes.

Establishing clear and actionable improvement strategies for the workforce to grow and thrive is imperative. Based on the data shared in this report and relevant literature on peer-delivered services, we recommend that OHA supports the following efforts to support the peer-delivered services workforce:

Advocate for adequate wages and growth opportunities within the peer workforce. To maintain a healthy workforce, wages should align with the job's high emotional demand and demonstrate

appreciation for the challenging and skillful work that peer delivered services provide. Opportunities for career pathways within the peer workforce are needed to retain and maintain a strong workforce, in addition to ensuring persons with lived experiences are reflected at all levels organizationally.

Encourage ongoing advocacy to increase awareness and understanding of the role and value of peer delivered services. Share information with coordinated care organizations, communities and organizations about the roles of peers to highlight their importance as integral members of care teams, and to decrease ambiguity about their roles. Provide leadership and advocacy training to peers to fully engage in discussions that impact the peer workforce – nothing about us, without us!

Support certification and training standards, which align with peer-delivered services models of support and collaboration, enhance fidelity, and streamline certification processes while ensuring candidates have lived experience. Revisit stringent criminal background check standards, which can reduce the workforce and limit job opportunities for qualified candidates. People from underrepresented communities in the peer workforce may have disproportionate rates of arrests, convictions, and incarcerations leading to lack of diversity in the workforce. Increase training availability in areas where training is not yet provided.

Address insufficient funding opportunities for peer-run programs and services to create sustainable funding opportunities that align with services being delivered, and promote diversity, equity, and inclusion. Model transparency and provide technical assistance to diverse programs and organizations to access funding resources. Provide opportunities for the peer workforce to share input and impact policy and funding opportunities.

Improve access to peer workforce connection and networking opportunities to address feelings of pressure related to being the "only peer" within an agency and promote self-care and development through positive support opportunities.

Support development of job descriptions that promote peer role fidelity and values. Provide peer-directed technical assistance and examples of peer-delivered services job descriptions that maintain role fidelity. Ensure job descriptions do not include responsibilities and duties that would result in dual-relationships (e.g. role is part-peer support specialist and part-case manager). Recognize transportation barriers that may impact workforce members, especially communities of color that may have less access to a vehicle due to racism, wealth and income disparities, and racially discriminatory pricing practices.[16]

Streamline and support standards around peer-delivered service supervision. Include budget lines for peer supervision within grants, contracts, and other funding opportunities. Widely distribute existing peer supervision standards, like the SUD peer supervision competency document developed by MHACBO and OHA's draft peer support supervision recommendations. On the OHA THW Registry, include a classification for peer supervisors that is publicly available and easily searchable. Provide foundational peer supervision training to support the development of new supervisors, especially in rural or frontier areas where supervision is not currently available.

[16] Car Access: National Equity Atlas. (n.d.). Retrieved September 27, 2020, from https://nationalequityatlas.org/indicators/Car_access

Peer-Delivered Services

Online survey for current, past, and future members of the peer workforce in Oregon

MHAAO and OPDSCo developed a peer-delivered services workforce 48-question survey, adapted from a template provided by OHA's Office of Equity and Inclusion. The survey drafts were shared for feedback and revision across many sources, including the OPDSCo Steering Committee, Advisory and Evaluation Committee, leaders in the peer community, OEI staff, and peer-delivered services workforce members. One of the data collection methods for the needs assessment to better understand successes, challenges, and needs within the peer-delivered services workforce, the survey was online for approximately a year, from August 2019 – July 2020.

This report summarizes the findings from that survey, available for participants in direct service or leadership roles in the peer-delivered services workforce, or aspiring to join the workforce post-training. The full results are available in the appendices.

Data Collection

Workforce online surveys

Participants

401 **Members of the peer workforce**

36/36 **Counties represented**

This survey was developed to address 4 primary aims:

AIM 1: Describe the successes and challenges in the peer-delivered services workforce, including barriers to entry and retention.

AIM 2: Identify training and workforce development gaps for peer-delivered services.

AIM 3: Better understand how to improve support of the peer-delivered services workforce, and what needs workers face.

AIM 4: Identify sustainability strategies for peer-delivered services, including ways in which reimbursement may be improved.

AIM 5: Describe the working conditions for those in the peer workforce, including pay, benefits, and workplace attitudes.

Participants shared varied experiences around 7 key topic areas.

Findings

Participants

The average age of survey participants was 47 years old. Most participants identified as female (62%), followed by 29% male, 2% gender fluid, and 2% non-binary. One percent of participants identified as gender nonconforming, and less than 1% identified as either transgender, genderqueer, gender expansive, or questioning. A majority of participants identified as heterosexual (72%), followed by 7% identifying as bisexual, 5% as lesbian, 3% as queer, and 2% as gay. Some declined to answer and less than 1% identified as questioning. The peer workforce is more diverse with respect to gender identity and sexuality than Oregon; a 2016 Gallup poll estimates that 4.9% of Oregonians identify as lesbian, gay, bisexual, or transgender

Participants (n=312) were asked which racial or ethnic identify that best represents their primary racial or ethnic identity. Most identified as European or white. Reviewing data from the OHA THW registry, inclusive of all certified peer-delivered service worker types, it is difficult to compare as 80% of the peers on the THW registry did not indicate any response related to primary racial or ethnic identity.

Which of the following describes your racial or ethnic identity?	Count	Percent
Western European	108	21.56
Other White	56	11.18
Eastern European	40	7.98
American Indian	25	4.99
Hispanic or Latino Mexican	17	3.39
African American	12	2.40
Other (please list)	12	2.40
Don't want to answer/Decline	11	2.20
Slavic	9	1.80
Other Hispanic or Latino	6	1.20
Don't know/Unknown	6	1.20
Middle Eastern	4	0.80
Indigenous Mexican, Central American or South American	3	0.60
Hispanic or Latino Central American	3	0.60

Certification and Peer Worker Type

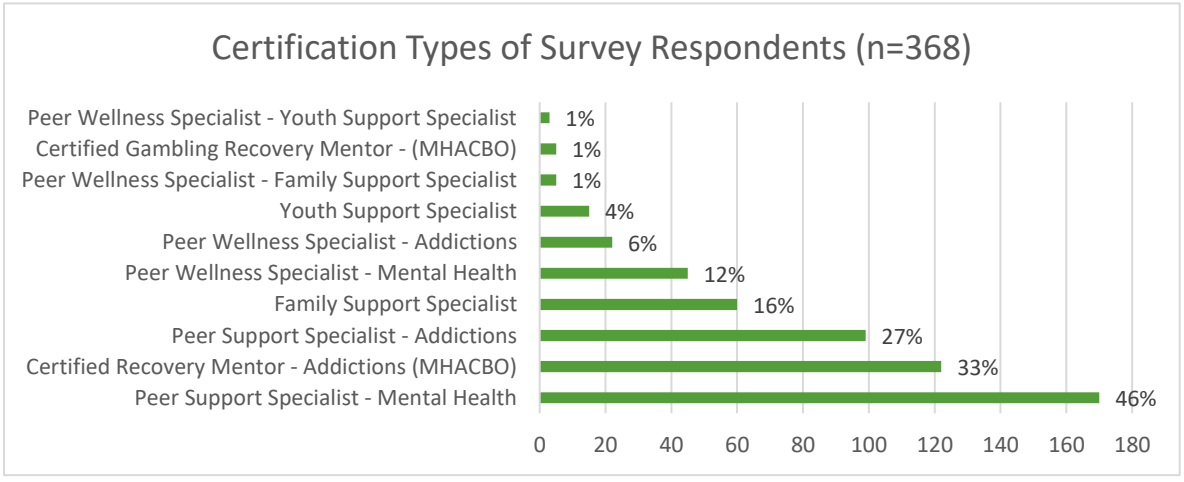
Participants were asked which type of peer-delivered services worker they most closely identify with and work primarily within in their peer role. Individuals working within peer delivered services must have the lived experience that qualifies them to do this work.

Peer Worker Type Identification	Count (n=401)	Percent
Peer Support Specialist – Mental Health	157	39%
Certified Recovery Mentor - Addictions	76	19%
Peer Support Specialist - Addictions	61	15%
Family Support Specialist	56	14%
Peer Wellness Specialist – Mental Health	24	5%
Peer Wellness Specialist - Addictions	8	2%
Youth Support Specialist	12	2%
Peer Wellness Specialist – Family Support Specialist	5	1%
Certified Gambling Recovery Mentor - Addictions	2	<1%
Peer Wellness Specialist – Youth Support Specialist	0	0%

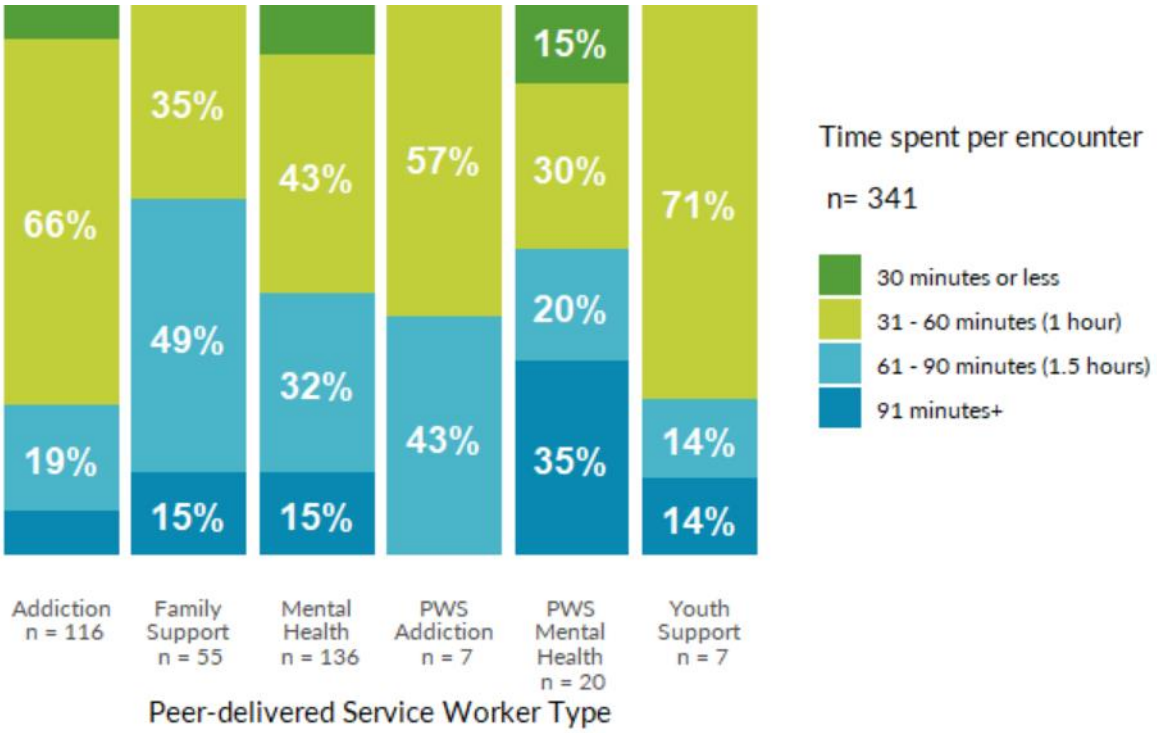
Due to small numbers of respondents in several of the peer worker types, relevant worker types were grouped together—based on lived experience – for data analysis purposes. The six analysis categories are below.

Peer Support Type	Count (n = 401)	Percent
Mental Health	**157**	**39%**
Addiction	**139**	**34%**
Family Support	**61**	**15%**
PWS - Mental Health	**24**	**5%**
Youth Support	**12**	**2%**
PWS - Addiction	**8**	**2%**

Most participants were certified within their worker type, and eighty-three participants (22%) experienced barriers to certification, with many reporting that the background check process was the primary barrier. Participants also indicated that delays and long wait times for processing were another major barrier.



Workload



Across peer-delivered service worker types, most meetings with people receiving services are longer than 30 minutes. Of worker types, family support specialists and peer wellness specialists in adult mental health tended towards longer meetings of over an hour.

The average numbers of individuals that a peer-delivered service worker sees per month is 29, with 243 (69%) participants reporting that they do not have a waitlist. Of the 62 respondents who had a waitlist, the mean number of people on it is 22.

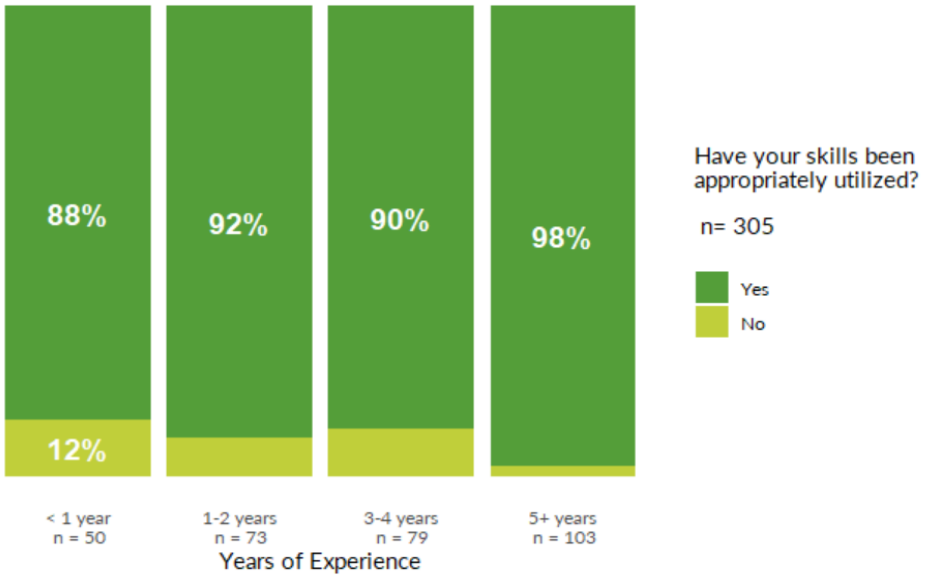
Do you ever have to turn away potential individuals who would like to receive peer support services?		
Response	**Count (n = 348)**	**Percent**
No	**217**	**62%**
Yes	**81**	**23%**
Don't Know/Unknown	**50**	**14%**

Eighty-one participants (23%) shared that they have to turn away potential individuals who would to receive peer support services. The primary reason given for turning away a potential peer was because of full caseloads: "more people wanting the service than we have capacity to serve." Several participants mentioned turning away someone due to a lack of culturally and linguistically-specific services. Over half of 348 respondents (57%) work fulltime, between 32 – 40 hours a week in their peer roles. Nearly 80% are satisfied with the number of hours they work.

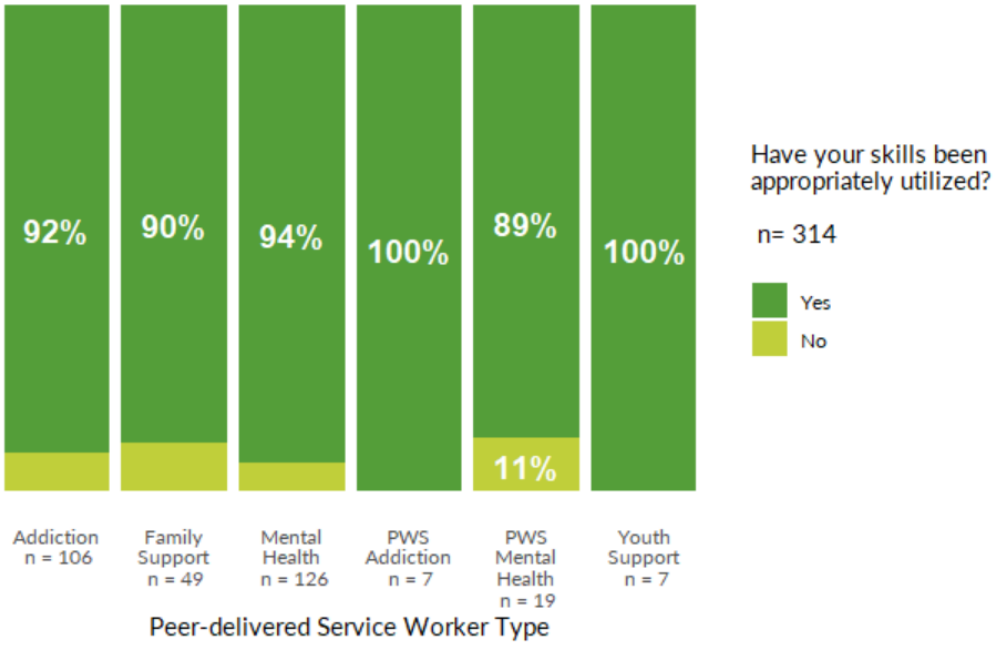
Employment

Around one in ten participants shared that they have experienced difficulty finding work since becoming a peer-delivered services provider. Limited job opportunities available was listed as a barrier, with "more applicants than positions." Inadequate hours and wages were also listed as a barrier, with participations mentioning that the "salary is low for the work we do" and "jobs pay very little." A few participants also shared that needing a car and organizations not understanding the peer role were challenges.

Across worker types and years of experience, most participants have had their skills as a member of peer workforce appropriately utilized.



The respondents (7%) who had done work outside of what they were trained to do within their scope of practice as a peer, reported that they have done case management (without training or pay increase) and also been responsible for clinical tasks, chores, or errands.



Nearly 90% of participants (n=287) believe they have the sufficient skills and support to do their job. A lack of training opportunities was listed as a barrier to skill development, in addition to a lack of supervision time. Twenty percent of participants do not have adequate training opportunities available in their area to support skills development.

Participants were asked to share the types of training opportunities or courses that would best help them develop skills related to their job.

Participants listed several specific training courses, such as:	
► Working with non-peer colleagues	► Harm reduction
► Advocacy	► Intentional Peer Support
► Parenting skills	► Mental Health First Aid
► Technology skills	► Trauma-Informed Care
► Boundaries	► Outreach support
► Medication Assisted Treatment	► Ethics
► Motivational Interviewing	► Peer scope
► Counseling	► Personality disorders
► Communication skills	► Rapport building
► Forensic peer support	► Time management
► Hearing Voices Facilitation	► Self-Empowerment
► Support working with different populations of people (e.g., veterans, people experiencing homelessness, LGBTQ)	► WRAP
	► Writing clinical notes
	► Pregnant women and addiction
Participants listed several specific opportunities, such as:	
► Trainings in Spanish or other languages	► More online trainings
► Affordable CEU courses	► More trainings in rural areas

Current Workplace

In your workplace, how many other peer workers are there (not including yourself)?		
Response	**Count (n = 308)**	**Percent**
10+ other peer workers	**73**	**24%**
2-3 other peer workers	**58**	**19%**
4-5 other peer workers	**39**	**13%**
There is one other peer worker	**39**	**13%**
I'm the only peer in my work environment	**37**	**12%**
6-7 other peer workers	**31**	**10%**
8-10 other peer workers	**31**	**10%**

Over a third of survey respondents have been employed in their current peer-delivered services job for more than three years, and 5% are not currently employed. Seventy-five percent of respondents report that there are two or more other peer workers within their workplace. Eighty-percent of employed participants (n=235) work within a non-profit organization and 22% work within peer-run organizations, with participants working across every one of Oregon's 36 counties.

"I love working with my clients. They are **wonderful people** who are **kind, caring,** and very **open-hearted**. I notice that **my mood improves** while working with them."

The favorite part of respondents' jobs was providing direct services to people. Within that, several themes were identified: making connections and building community, empowering people, hearing and sharing personal stories, helping people reach their goals, and celebrating successes.

" My favorite part of my job is **using my lived experience** to **make a difference** in **others' lives**."

Participants also reported on the least favorite part of their job: largely administrative work, including documentation and other paperwork tasks. Difficult situations with individuals receiving peer support (e.g. death, relapse, crisis), limited access to resources to support people, difficult and oppressive organizations and systems, and lack of understanding and respect for the peer role, were described as additional challenges by many participants.

What's your favorite part of your job?

"Empowering people to be an active participant in their health care/ substance use treatment/ mental health where they can build sustainable change in their lives."

"Knowing I can connect with the peers I provide services to and that I can make a difference in their recovery."

"Not having an agenda... simply meeting someone where they are at and supporting them with their goals."

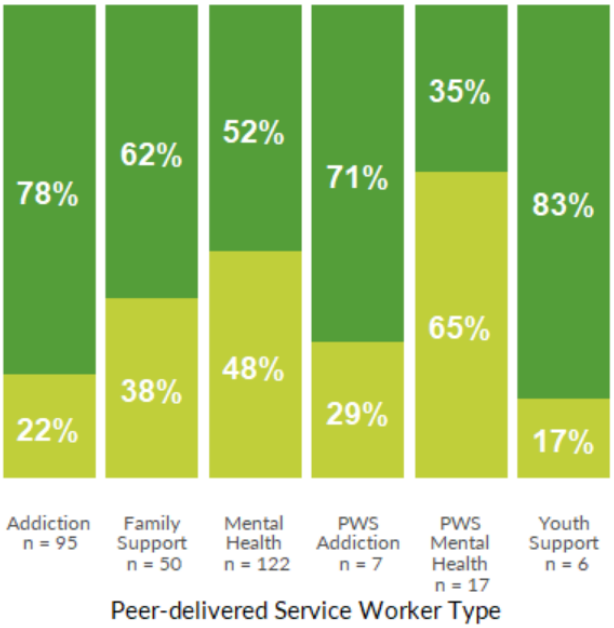
Just under half of participants (n=135) are interested or thinking about pursuing a new job or employer, with better pay and benefits listed as the biggest appeal.

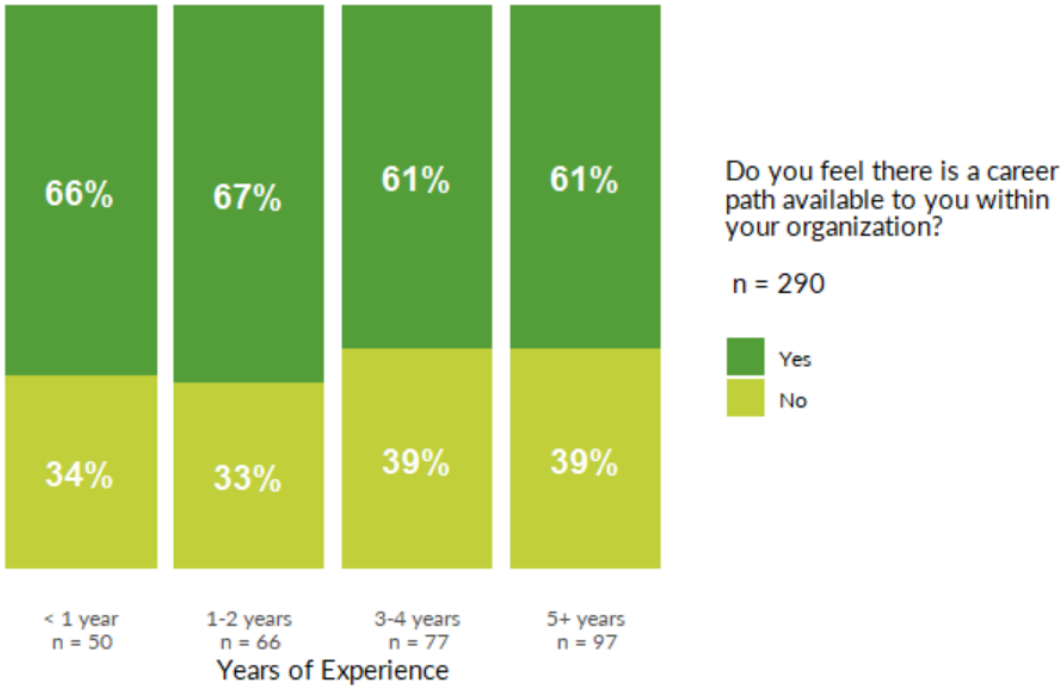
Workplace Attitudes

Twenty-nine percent of participants (n=89) do not consistently feel recognized and valued as a full member of their team. Participants offered suggestions on ways that would help them feel recognized and valued:

- Coworkers understanding and respecting peer role – and taking ownership of their own education
- Peer work being acknowledged and valued through recognition and positive affirmations
- Better pay
- More supportive and respectful organizational culture

Overall, participants were optimistic about the availability of a career path to them in their organizations. This trend can be examined by type of peer support worker and by years of experience as a peer-delivered service worker.

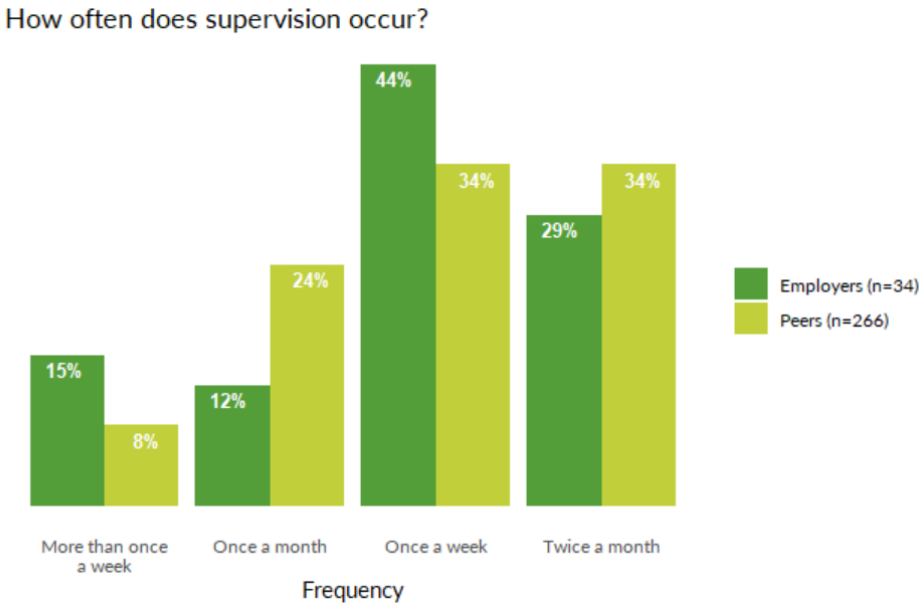




Participants with career paths available to them mentioned management, supervision, and leadership as options, in addition to positions outside of the peer-delivered services scope of practice, like counselor or case manager. Participants without career paths available to them listed a lack of advanced jobs as a barrier.

Most respondents (88%) feel valued in their position, and report that receiving affirmation, acknowledgement, and support from coworkers and leadership plays a significant role in feeling valued. Not feeling trusted or respected in their peer-delivered service position was the primary reason participants did not feel valued in their position.

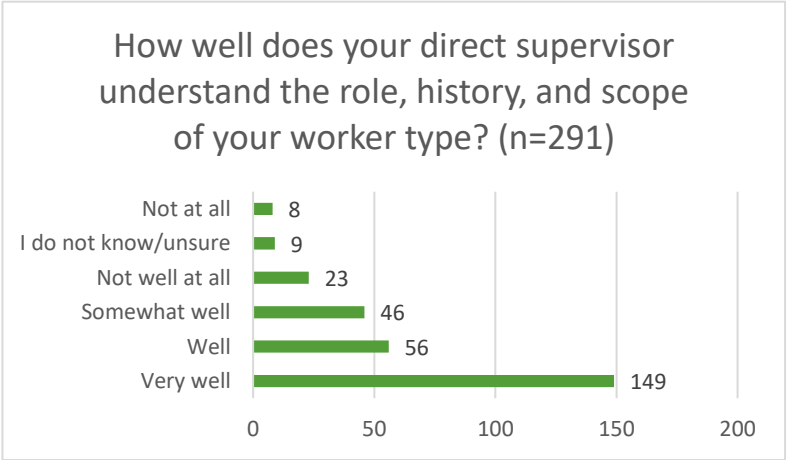
Supervision



Employers and members of the peer-delivered services workforce reported different frequencies with which supervision occurs, with employers stating that supervision occurs more frequently than those in direct service positions report. Some peer-delivered service providers said they receive supervision less frequently than every two months, or not at all (7%).

Participants had mixed feelings about the quality and frequency of the supervision they receive, with 68% highly satisfied or satisfied and a combined 32% somewhat satisfied, unsatisfied, or highly unsatisfied. Just over a third of respondents have a supervisor with lived experience, 24% share that their supervisor has clinical experience, while 28% of supervisors have both lived and clinical experience.

Most participants rated their direct supervisor as understanding of the role, history, and scope of their peer-delivered service worker type.



Medicaid and Payment Models

Under half (43%) of participants were very interested in being able to bill insurance of Medicaid for their peer support services, with another 21% being somewhat interested. Some participants were either not sure (18%) or not at all interested in billing insurance or Medicaid (17%).

Respondents were almost evenly split between being not at all intimidated by billing an insurance company or Medicaid (48%), finding it somewhat intimidating (34%), or very intimidating (18%).

Half of respondents have never successfully billed (through their agency) Medicaid for their peer-delivered services, while 34% have. When asked which payment reimbursement models they see as most beneficial for peer-delivered services, many participants (59%) noted that they were unfamiliar with payment reimbursement models. The next highest percentage (29%) were interested in fee-for-services models, followed by alternative payment models at 24%. When asked about experiences, including successes, any barriers, and challenges related to payment reimbursement, a participant commented, "I just know that my agency does it." Many others described similar situations.

Which payment reimbursement model(s) do you see as being most beneficial for peer-delivered services work?

Response	Count (n = 263)	Percent
Not sure/unknown	154	59%
Fee-for-service (FFS) (paid a fee for each service provided from an approved service list)	77	29%
Alternative payment model (APM) (payment other than FFS that is used to coordinate and integrate healthcare services. Provides added incentive payments to give high quality and cost-efficient care.)	64	24%
Values-based payment (VBP) (holds providers accountable for both the cost and the quality of care they deliver. Providers are rewarded financially for delivering better, more cost-effective care, and can be penalized for not meeting targets.)	44	17%

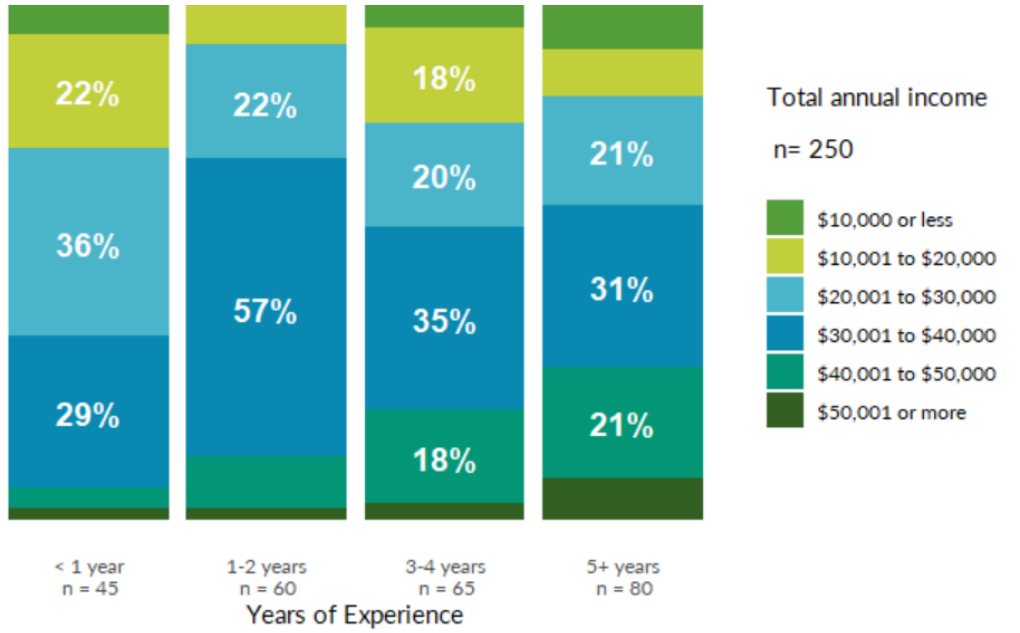
"Documentation is a **necessary evil.**"

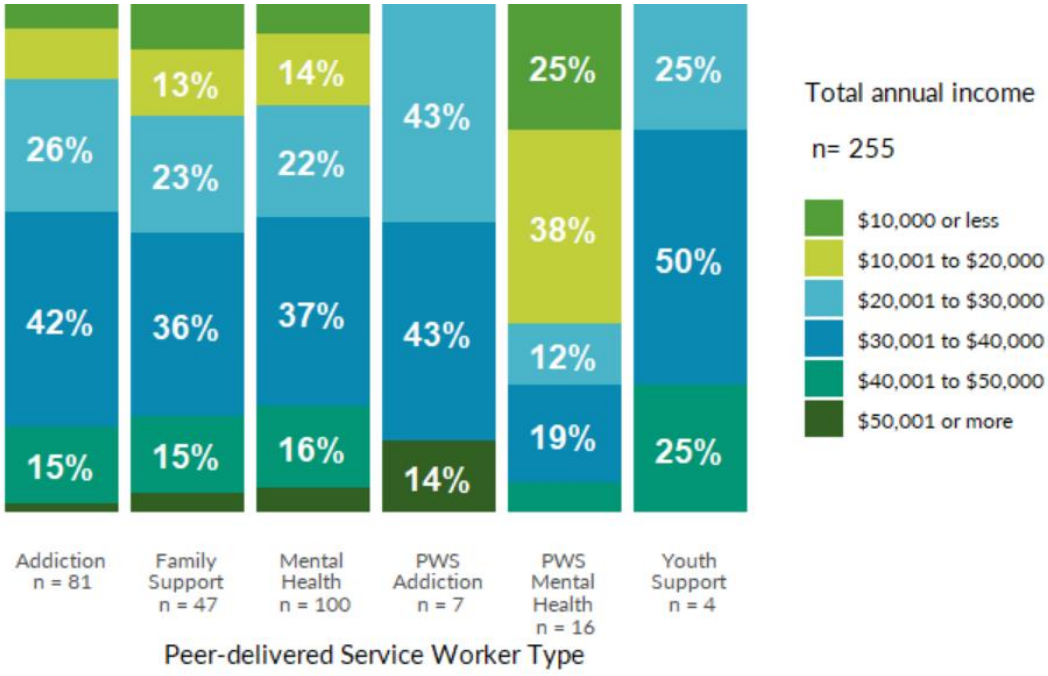
Some participants described being thankful that they can focus on providing peer services and consider themselves separate from the billing that is done in a separate department. This separation was seen as essential to being able to remain "fully authentic" in peer service delivery.

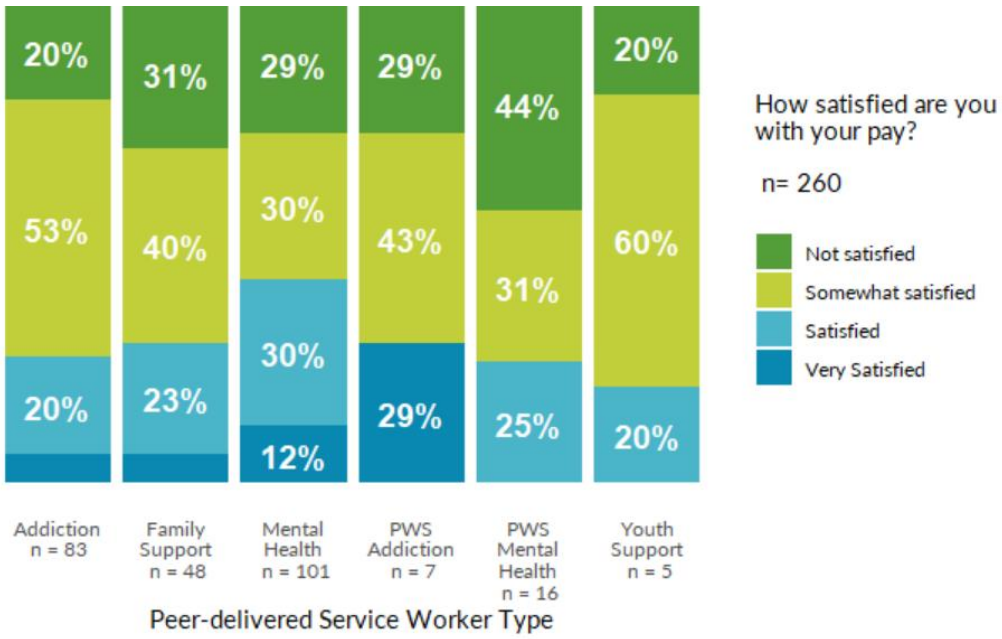
"Sticking to the treatment plan is a challenge because of how people's lives actually play out."

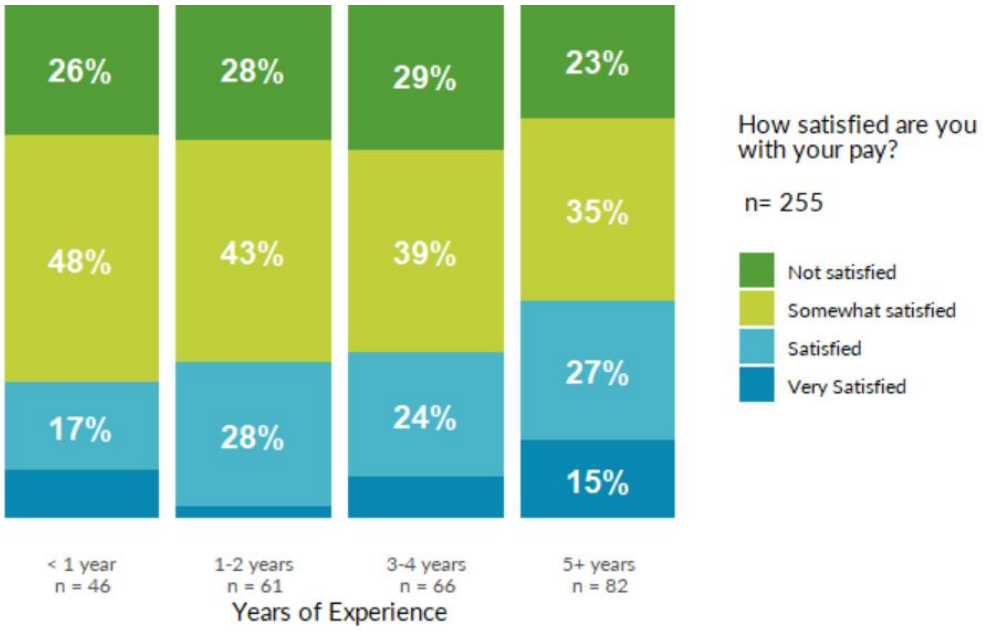
Pay and Benefits

The average respondent pay was $18.26 per hour. Total annual income varies based on years of experience and peer-delivered service worker type.

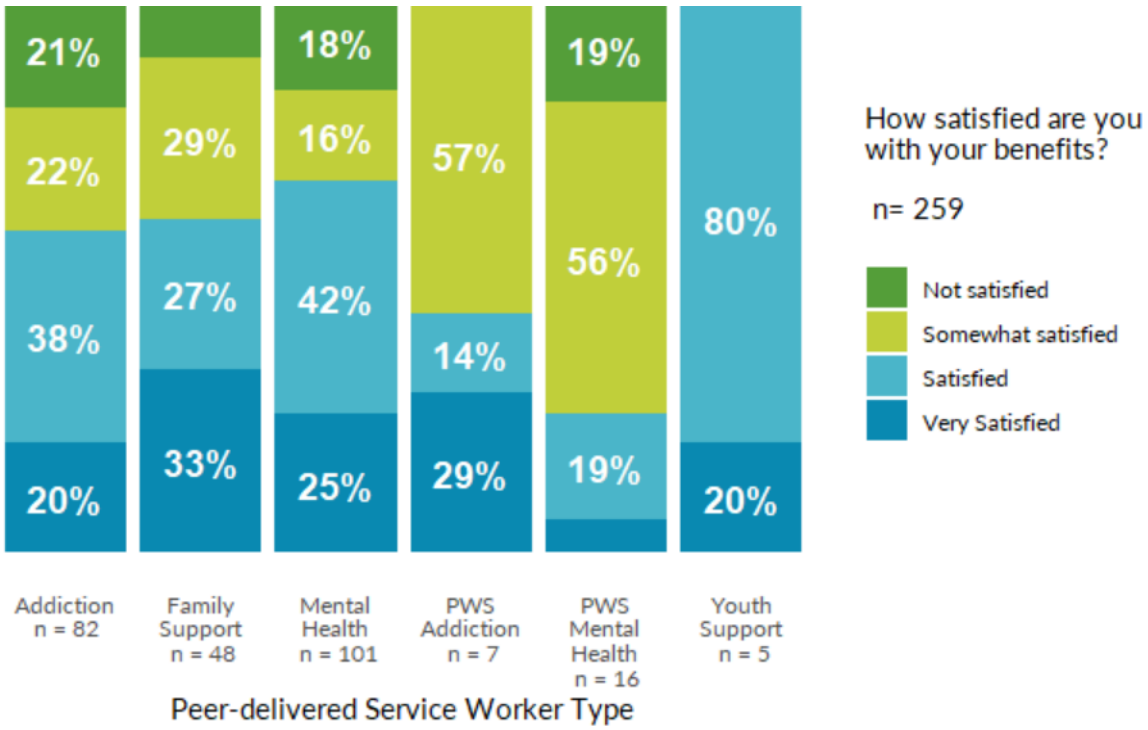


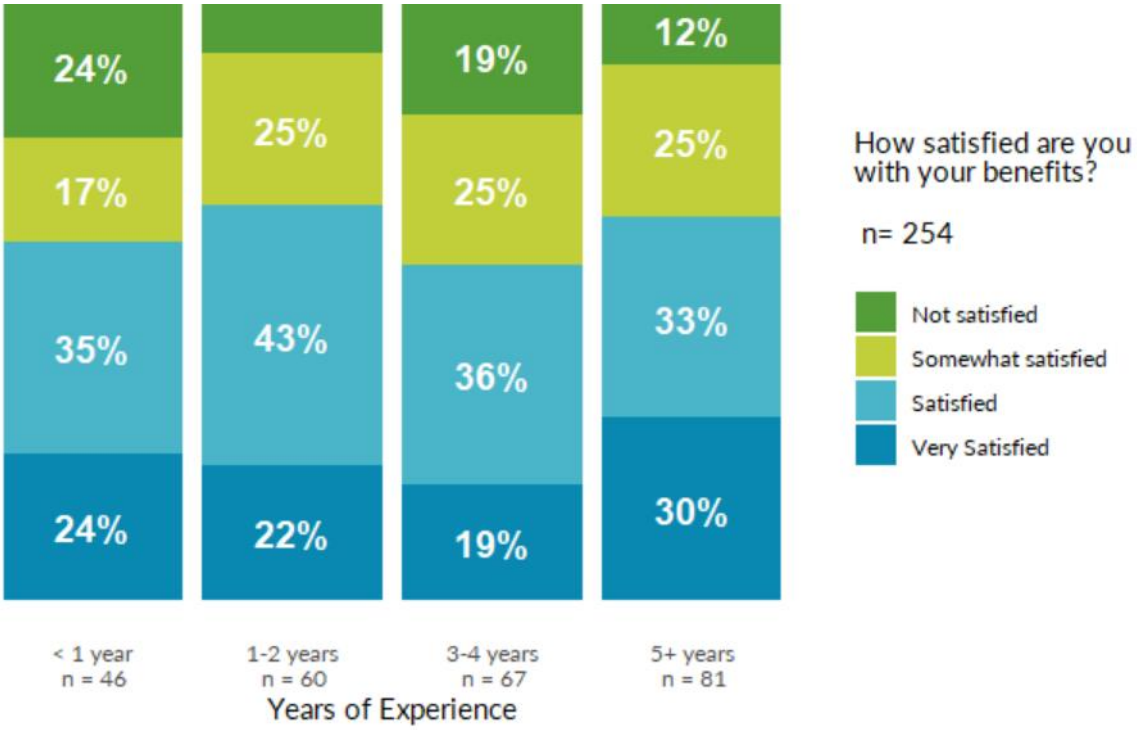






Across years of experience and worker type, participants tend toward not being fully satisfied with their pay. Higher numbers report satisfaction with their benefits than their pay. Participants with more years of experience in the field are more likely to be satisfied with their pay when compared to satisfaction across worker types.





Thirty-two percent of peer-delivered service workers say they are satisfied or very satisfied with their pay. The remaining 68% range between somewhat satisfied and not satisfied with their current pay.

Culturally- and Linguistically-Specific Services

A majority (56%) of participants report being able to provide culturally-and linguistically-specific peer support services. Of the participants who were unable or didn't know if they were able to provide culturally- and linguistically-specific services (n=117), 53% had the ability to connect with someone within their organization who would be able to provide those specific services.

Participants mentioned several barriers and challenges related to the provision of culturally- and linguistically-specific peer services:

- Lack of access to high quality interpreters
- Language barriers
- Lack of diversity in the peer workforce
- Varying needs of people served
- Lack of adequate training

Most respondents shared that the employees in their workplace reflect the diversity of the communities they serve.

Participants described ways to promote equity and inclusion and improve workplace diversity, with the most frequent suggestion to have more diversity in the workforce through training, hiring, and retention. Participants also want to have more trainings available, relevant to working with diverse culturally-and linguistically-specific groups. In addition, having more services available for diverse groups would promote equity and inclusion and improve workplace diversity.

REAL+D results are presented in the appendix of this report.

Conclusion and Recommendations

Participants shared their varied experiences as members of the peer-delivered services workforce across topics designed to better understand the needs, challenges, and successes of the workforce.

Peer-delivered services are growing rapidly in Oregon and nationally. Establishing clear and actionable improvement strategies for the workforce to grow and thrive is imperative.

Based on the data shared in this report and relevant literature on peer-delivered services, we recommend that OHA supports the following efforts to support employers of the peer-delivered services workforce:

Require organizations to have adequate peer supervision models and support organizations in training internal supervisors or contracting with peer supervisors who are experienced in understanding the role and scope of peer-delivered service positions. Ensure contract and grant funding is sufficient to cover increased costs related to supervision.

Provide funding opportunities to promote equity, inclusion, and diversity of the peer workforce, through increased contracting with and funding opportunities for culturally- and linguistically -specific programs to increase service availability and diversity of the peer workforce. Prioritize

funding for organizations led by and serving Black, Indigenous, and other communities of color. Provide technical assistance alongside newly awarded grants or contracts to support the success of the programs.

Advocate for adequate wages, benefits, and growth opportunities within the workforce. To maintain a growing workforce, wages and other benefits should align with the job's high emotional demand and demonstrate appreciation for required lived experience and work needed to understand the complex needs of people in which peers serve. Increased opportunities to move up within the peer workforce are needed to retain and maintain a strong workforce.

Encourage ongoing advocacy to increase awareness and understanding of the value of peer services, and to decrease stigma and discrimination. Share information with communities and organizations about the roles of peers to highlight their importance as integral members of care teams, and to decrease ambiguity about their roles.

Involve members of the peer-delivered services workforce and persons with lived experience in the planning, design, and implementation of policies and practices that impact the peer workforce. Ensure input opportunities are accessible and timely, with communications given with as much advance notice as reasonably possible.

Support individuals in accessing peer certification through the Oregon Health Authority, and provide technical assistance on navigating background check challenges, in addition to guidelines on background check requirements and exclusions. Provide clear and transparent communications about certification processing timelines.

Support increased access to continuing education for peer-delivered service providers, including development of culturally-and linguistically-specific peer certification trainings and continuing education opportunities, to decrease barriers to access to certification and workforce entry. Support training delivery in rural and frontier areas of the state., as well as the 28 counties that do not currently have state-approved certification training programs.

Peer-Delivered Services

Online survey for current and future employers of the peer workforce in Oregon

Mental Health & Addiction Association of Oregon (MHAAO) and Oregon Peer Delivered Services Coalition (OPDSCo) developed a 26-question employer survey adapted from a template provided by OHA's Office of Equity and Inclusion. The survey was created to collect data on opportunities, challenges, barriers, and recommendations for improving peer-delivered services integration in the state of Oregon. One of the data collection methods for the needs assessment to better understand successes, challenges, and needs within the peer-delivered services workforce, the survey was online for approximately a year, from August 2019 – July 2020. This report summarizes the findings from the peer-delivered services workforce employer survey.

Data Collection

Employer online surveys

Participants

49 **Employers**

36/36 **Counties represented**

This survey was developed to address 5 primary aims:

AIM 1: Describe the successes and challenges in employing the peer-delivered services workforce, including barriers to entry and retention.

AIM 3: Better understand how to improve support of employers.

AIM 4: Identify sustainability strategies for peer-delivered services, including ways in which reimbursement may be improved.

AIM 5: Describe the needs of employers to adopt and integrate peer-delivered services within their programs.

Participants shared their experiences as employers across five topic areas in the online survey.

Findings

Organizational background

Most employer participants classified their organization as more than one type (e.g. peer-run organization and non-profit). Over a third were non-profits, with frequent representation occurring from peer-run organizations (19), community-based organizations (18), and mental health or addiction provider (16). The median number of employees employed by respondents was 52.

Just under a quarter of participants were unsure of their organization's approximate annual operating budget (n=11), with the second highest number (9) reporting that their budget was between $1 and 4 million dollars annually. Participant organizations provide services across every county in the state.

Peer-delivered services within the workplace

How familiar is your organization with peer-delivered services?		
Response	**Count (n = 49)**	**Percent**
Extremely	**37**	**76%**
Moderately	**8**	**16%**
Slightly	**2**	**4%**
Somewhat	**2**	**4%**

Does your organization employ peer workers?		
Response	**Count (n = 49)**	**Percent**
Yes	**43**	**88%**
No	**5**	**10%**
I am not sure.	**1**	**2%**

Most participants reported being employers of peer workers, and a majority indicate being extremely familiar with peer-delivered services. The hourly wages for peer-delivered service position provided by participants ranged from $11.56 per hour to $31.00 per hour, with a median hourly rate of $17.00. The median number of persons employed in peer-delivered services positions was 6 per organization with 5 total full-time equivalency (FTE). Many participants (51%) reported being unclear which specialty type(s) of peer-delivered service worker was employed with their organization.

Only 15% of participants (n=6) do not currently contract with – or are themselves–community-based organizations to provide peer-delivered services.

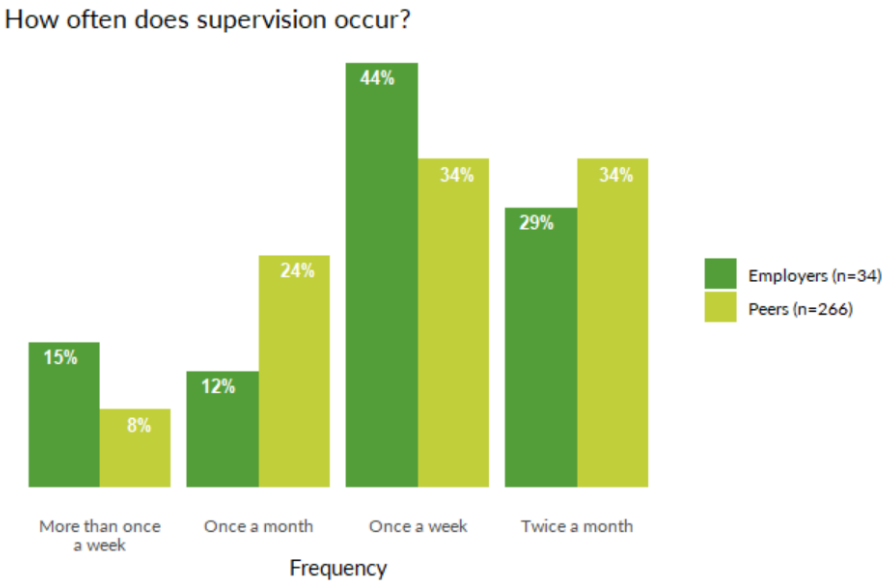
Almost all participants would like to be able to offer peer-delivered services to those who receive services at their organization, and over half currently offer peer services.

Hiring and retention

Fifty-five percent of respondent organizations (n=22) have experienced challenges in hiring and retaining qualified peer-delivered service providers. Challenges reported by participants included:

- Finding qualified candidates
- Ability to provide appropriate supervision
- Ability to provide competitive wages and benefits
- Peer workers maintaining recovery and appropriate boundaries with people being served
- Ability to maintain consistent funding and people to serve
- Finding candidates with diverse backgrounds

Supervision



Employers and members of the peer-delivered services workforce reported different frequencies with which supervision occurs, with employers stating that supervision occurs more frequently than those in direct service positions report. Some peer-delivered service providers (7%) said they receive supervision less frequently than every two months, or not at all.

Employer participants were asked how supervisors of peer-delivered services staff are supported to understand the role, scope, and values of peer support positions, and selected all relevant options below:

Response	Count (n = 38)	Percent
Supervisors have access to as-needed supervision and technical assistance	**23**	**61%**
Supervisors receive relevant training prior to working with peer staff	**22**	**58%**
Supervisors of peer workers have experience working within peer roles themselves	**20**	**53%**
Supervisors are provided materials on peer delivered services in Oregon to review	**19**	**50%**
I am not sure	**9**	**24%**
Supervisors are not provided any additional or special support	**2**	**5%**

Payment models and reimbursement pathways

About half of participants' organizations fund peer positions through county grants or contracts, followed by state grants or contracts at 28% (n=11). Most participants reported being very interested in being able to bill insurance or Medicaid for peer-delivered service positions. Of those who employ Oregon Health Authority-approved peer traditional health workers, 18% of agencies have successfully billed and been reimbursed by Medicaid for peer support services (n=6).

Participants described their experiences with Medicaid or other payment reimbursement for peer-delivered services primarily in terms of challenges, including:

- Reimbursement rates not covering the cost of peer positions

    - Travel time is not reimbursable, and creates significant barriers in rural and frontier Oregon
    - Not all peer time is Medicaid-reimbursable, including outreach and engagement activities
- More codes and modifiers need to be created for better sustainability
- Billing process leads to role confusion and creates scope creep for peer-delivered service roles
- Challenges renewing contracts

Several participants mentioned not having any problems with payment reimbursement, and a few shared that they do not bill for services. Many (35%) were unsure as to the most beneficial payment reimbursement model for peer-delivered services, while of participants reported that fee-for-service or alternative payment models would be best.

Which payment reimbursement model(s) do you see as being most beneficial for peer-delivered services work?		
Response	**Count (n = 37)**	**Percent**
Not sure/unknown	**13**	**35%**
Fee-for-service (FFS)	**12**	**32%**
Alternative payment model (APM)	**11**	**30%**
Values-based payment (VBP)	**9**	**24%**
Other - Write In **We have been open to different kinds of contractual relationships.** **We wish to keep ours a no fee organization.**	**3**	**8%**

Participants offered suggestions to improve payment reimbursement models for peer-delivered services. A reoccurring recommendation was for payment reimbursement to fund a peer position instead of services as that better aligns with a client/peer-centered approach. Concerns about fidelity to a peer model were raised by participants.

> **"To provide true peer delivered services, peers should not have to be constrained by Medicaid regulations, which tie peers into providing a set list of services and not being able to provide what the consumer needs."**

Participants described the challenges of unclear contracts with complex reporting requirements, putting peer-delivered service providers at risk of presenting themselves in a way that is less aligned with the peer role and values.

Respondents were asked which funding sources they would be most interested in pursuing should the option be made available, and ranked the below options from 1 – 5, with 1 being "most interested" and 5 being "least interested". Participants also had the option for "I am not sure."

	1	2	3	4	5	Unsure.
Contract with coordinated care organizations (CCOs)	17 (49%)	9 (26%)	4 (11%)	5 (14%)	0	0
Contract or receive grants from state or county	18 (53%)	8 (24%)	5 (15%)	1 (3%)	2 (6%)	0
Contract with peer providers who directly bill Medicaid themselves	3 (9%)	4 (12%)	9 (28%)	5 (16%)	5 (16%)	6 (19%)
Bill Medicaid	6 (19%)	4 (13%)	10 (32%)	3 (10%)	5 (16%)	3 (10%)
Directly bill private/commercial insurance	5 (16%)	4 (13%)	13 (42%)	0	5 (19%)	3 (10%)

Participants reported being most interested in contracting or receiving grants from the state or county as a funding source, followed closely by contracting with coordinated care organizations.

Culturally- and linguistically-specific services

Most participant organizations (69%) report being able to provide culturally-and linguistically-specific peer support services. Of those unable to provide specific services, an additional 45% possess the ability to connect with someone outside of the organization who can provide culturally-and linguistically-specific peer-delivered services. Most organizations (72%) also report their workplace reflecting the diversity of the communities served.

Participants described ways to promote equity and inclusion and improve the diversity of their workplaces, including:

- Implement better recruitment strategies
  - Simplify the application process
  - Intentional recruitment and relationship-building with diverse communities
  - Support connecting with a more diverse pool of peer-delivered service workers
- Ability to offer more stable employment through financial sustainability
- Better understanding of diversity within communities, and of the resources available
- Increase diversity of peer workforce overall

Barriers, successes, and technical assistance

Barriers

Participants who do not currently offer peer services reported several items that would be necessary for its implementation, including funding and contracting opportunities, and needing to have a peer-delivered services job category approved by leadership.

Participant employers described several barriers to supporting peer-delivered service positions within their organizations. The most commonly cited barrier was understanding the role of peers, followed by a need to build a sustainable infrastructure for the workforce. The challenge of funding and inability to provide adequate supervision arose several times.

Successes

> **"We get to employ the so-called unemployable to give voice to those who don't know they have a voice."**

Participants shared many benefits and successful experiences as a result of having peer positions within their workplace. Several key themes came up related to successes, including:

- Shared experience provides hope for people
  - Services can be received with less fear of judgment or shame
  - Unique ability to build relationships with those receiving services
  - Ability to walk alongside others is very beneficial
- Increased engagement from those receiving services or supports
- Better outcomes for individuals receiving peer-delivered services

Technical Assistance

Sixty-percent of respondents expressed an interest in learning more about peer-delivered services. Participants were asked what technical assistance they would be most interested in receiving, most expressing interest in multiple methods of technical assistance delivery. Experiential learning via a site visit to a location providing peer-delivered services was ranked most appealing at 64%.

What technical assistance would you be most interested in receiving?		
Response	**Count (n = 22)**	**Percent**
Visit to a site providing peer delivered services	**14**	**64%**
Two-hour onsite training	**13**	**59%**
One-hour webinar	**12**	**55%**
One-page informational sheet on peer delivered services	**11**	**50%**
Presentation by consumers/members receiving peer delivered services	**11**	**50%**

Conclusion and Recommendations

Participants shared their varied experiences as current or prospective employers of peer-delivered service providers, their barriers to integrating peer staff, and their insights about the payment reimbursement pathways. Peer-delivered services are expanding rapidly in Oregon. The organizations and systems that employ the workforce are foundational to its success. Establishing clear and actionable improvement strategies for the workforce to grow and thrive is imperative.

Based on the data shared in this report and relevant literature on peer-delivered services, we recommend that OHA supports the following efforts to support employers of the peer-delivered services workforce:

Develop ways to address compassion fatigue, vicarious trauma, and burnout, which lead to high rates of turnover. Require organizations to have adequate supervision models and encourage peer connections across the state, including building on current support models, to support retention and increased health and wellness of employees.

Provide technical assistance opportunities on accessing public funding streams, to increase familiarity with funding options available to employers specific to peer-delivered services. Support connections between coordinated care organizations, OHA, and peer programs, with technical assistance provided to all parties as needed.

Increase funding opportunities available for peer-delivered services programs, and ensure sufficient funds to cover living wages and benefits for peer staff, peer supervision, outreach and engagement, and travel time through reimbursement pathways that allow for fidelity to peer scope of practice. Increase contract clarity and transparency, and simplify reporting requirements to ensure fidelity to peer model. Adequate funding increases financial stability of organizations, which was cited as a barrier to hiring and retaining culturally- and linguistically-specific peer-delivered service providers, in addition to providing competitive wages and benefits.

Strengthen existing guidelines around best practices for contracting with community-based organizations to reduce confusion about peer roles and educate prospective funders and contract administrators about ways to contract with peer-delivered service providers and programs.

Promote co-supervision as a best practice, ensuring that all peer-delivered service workers have access to peer supervisors who are familiar with the role and scope of peer-delivered service positions, and themselves have lived experience. Require co-supervision (or direct supervision by a peer) for OHA contracts and grants.

Peer-Delivered Services

Interviews with people in the peer-delivered services workforce in Oregon

September 2020

The Oregon Health Authority (OHA)'s Injury and Violence Prevention Program contracted Comagine Health to assess the successes, challenges, and gaps within Oregon's peer-delivered services workforce using Overdose Data to Action (OD2A) grant funds. Mental Health and Addiction Association of Oregon (MHAAO) and Oregon Peer Delivered Services Coalition (OPDSCo) were funded by OHA's Office of Equity and Inclusion (OEI) to better understand needs within the peer-delivered services workforce. Comagine Health, MHAAO, and OPDSCo partnered to conduct interviews with people in Oregon's peer-delivered services workforce to leverage funding across the projects and reduce participant burden. Findings presenting in this report align with the aims of the OD2A funding.

This report summarizes the findings from interviews conducted April to June 2020 with participants in direct service or leadership roles in the peer-delivered services workforce. Participants reported working in many areas, such as mental health, substance use disorder, family services, and pain management, and reported various certification types, including peer wellness specialist, certified recovery mentor, peer support specialist, youth support specialist, and family support specialist.

Data Collection

Phone interviews with people delivering peer services in Oregon

Participants

20 peers in direct service roles

8 peers in leadership roles

These interviews were developed to address 5 aims:

AIM 1: Describe the successes and challenges in the peer-delivered services workforce.

AIM 2: Identify training and workforce development gaps for peer-delivered services.

AIM 3: Identify linkage to care and services successes and challenges to better align and scale up existing peer delivered services.

AIM 4: Identify sustainability strategies for peer-delivered services, including ways in which reimbursement may be improved.

AIM 5: Understand the impacts of COVID-19 on the peer-delivered services workforce.

Three key takeaways from the findings:

- Adequate wages, benefits, and growth opportunities are needed to grow the workforce.
- Burnout, vicarious trauma, and compassion fatigue are widespread and additional supports are needed.
- Information-sharing about the value and function of peers is needed to highlight their importance as integral team members, to clarify their roles, and to increase awareness of peer services more broadly.

Findings

"I just think that peer support is more than just a movement. I think it's a lifestyle and it is a way of life. We're useful and we need to be taken seriously. We know how to help each other."

Participants shared their experiences providing peer-delivered services in Oregon across 7 topics areas.

Organizational Background

Participants provided information about their organizations' goals and services. Participants reported working with the following diverse organizational types, some of which are peer-led and operated:

- State and local health departments
- Treatment and recovery organizations
- Hospitals and emergency departments
- Harm reduction agencies
- Crisis lines
- Advocacy organizations

Organizational goals included promoting empowerment; providing a welcoming, non-judgmental space for services; serving vulnerable populations (e.g., people with substance use disorder (SUD), people living in rural areas, people living with HIV, people experiencing chronic pain, people experiencing homelessness, veterans); supporting prevention, recovery, advocacy, and education; and reducing recidivism.

Organizational services were varied. Some participants described working for organizations that mainly focused on peer-delivered services and others worked for organizations in which peer-delivered services were a component of broader programming. Participants described working as a peer in organizations that provided SUD treatment services, mental health services, training services, social services, advocacy and policy change efforts, employment services, infectious

Peer-delivered services

Peer-delivered services are expanding rapidly. In Oregon, peer-delivered services are based in a variety of settings, including hospitals and emergency departments, jails and prisons, treatment and recovery agencies, and other community-based organizations (e.g., syringe service programs). Services are often focused on supporting people as they navigate mental and physical health needs, substance use disorders, and other social and behavioral needs. Because of shared lived experiences, peer-delivered services provide strong personal connections and hope. The shared life experience helps to build trust and overcome the power differentials in healthcare and behavioral and social services.

Through the OHA, peer workers can become state-approved as **traditional health workers** (THWs). There are 5 different types of THW as defined by the OHA. Two of the 5 types are specific to the peer workforce: peer support specialist (PSS) and peer wellness specialist (PWS). Both worker types have numerous sub-types in line with the lived experience of the PSS or PWS (e.g. mental health, addictions, family support, youth). The PSS and PWS have two specific sub-types of family support specialist and youth support specialist, within which both may work in mental health, addiction, and other peer-related capacities related to their lived experience.

disease screening, syringe exchange and other harm reduction services, telemedicine, and housing services. About half of the participants reported working for organizations with rural or coastal service areas and the other half worked for organizations with statewide service areas or a focus in the Portland tri-county area.

Participant Background

Participants provided information about their individual backgrounds and experiences, including their certifications and their roles and responsibilities in the workplace. Many participants reported having multiple certifications. Most were certified as peer support specialists and/or certified recovery mentors (CRM). Some were also certified as peer wellness specialists, family support specialists, or youth support specialists. Some participants reported diverse non-peer related certifications and degrees, such as Oregon Health Plan application assister, Sponsors to Assist Refugees (SOAR), certified alcohol and drug counselor (CADC), first aid certified, mental health coach, Hearing Voices Network facilitator, and counseling psychologist. A couple participants have not completed their certification because of delays due to COVID-19.

In their work, participants described providing peer-delivered services in a wide variety of settings, such as:

- Community (e.g., homeless outreach)
- Health care (e.g., hospitals and emergency departments)
- Residential (e.g., transitional housing, inpatient treatment)
- Corrections (e.g., jail, prison, drug court)
- Substance use organizations (detox, treatment, recovery)
- Harm reduction organizations

As one participant described, peer-delivered services are "more than a job, it's a lifestyle for me, and I really like it." Several participants shared a similar sentiment as they described the specific roles and responsibilities of being a peer-delivered services provider. Responsibilities include:

- Coordinating and attending appointments
- Supporting access to basic needs – housing, food boxes, etc.
- Conducting community outreach
- Networking and relationship building
- Providing transportation
- Providing family support
- Supervising other peer-support providers
- Facilitating groups
- Providing harm reduction services
- Conducting infectious disease testing
- Conducting urine drug screenings
- Providing peer consultation services to health care clinics, community-based organizations, national technical assistance

"The clinic is really comprehensive, and it offers services on so many different levels to our patients. That's why I feel so strongly about the peer support role in those services because if you take away the peer support role, then you don't have that glue. You don't have that wraparound affect."

"I went to school to be a drug and alcohol counselor, and I took my CADC because I do substance in groups and stuff. I loved being a mentor, and so I just never wanted to only be a counselor."

"Another piece of it is using my own lived experience to advocate and also help bring perspective around navigating systems of care with mental health and addictions."

- Advocating and lobbying for peer-delivered services
- Conducting service intakes and discharges
- Developing trainings and curricula
- Attending training sessions

Certification Processes Successes and Challenges

Participants shared their experiences completing peer-delivered services certification and renewal processes. Participants reported receiving their certification through OHA and/or the Mental Health & Addiction Certification Board of Oregon (MHACBO), which are the 2 credentialing bodies in Oregon.

Participants certified through OHA and MHACBO described **positive experiences** during the certification and renewal processes, specifically:

- **Feeling empowered, welcomed, validated, and valued,** especially through sharing of lived experiences
- **Appreciating the interactive format of the curriculum**, which uses popular education methods that support diverse learning styles
- **Learning new information that could be practically applied to their work**, including new content from instructors and life experiences from fellow participants
- **Easy access to online resources, trainings, and renewal**
- **Helpful and knowledgeable training and certification staff** who were easy to reach with questions
- **Opportunities to network**, which included meeting other peers in the workforce and receiving job offers

Participants specifically mentioned trainings related to motivational interviewing, intentional peer support, and ethics as being the most enjoyable and informative.

Participants certified through OHA described some **negative experiences** during the certification and renewal processes, specifically:

- **Long wait times to finalize certification and renewal process**, which led to inability to bill worked hours, loss of job opportunities, and concerns about losing current jobs
- **Lack of communication about certification and renewal status**, including not receiving call-backs about status or reminders about renewals
- **Confusing and ambiguous processes**, such as lack of clear guidance or responses to questions, inaccessible website resources, cumbersome application, and lack of resources to track continuing education credits
- **Staff in certification office not having lived experience**, which did not align philosophically with peers' expectations
- **Lack of consistency in trainings**, which leads to different levels of readiness when entering the workforce

"[Respecting lived experience] shifts your whole paradigm, and also that sense that this is a really incredibly valuable part of who you are as a person"

"[Presenters] really encouraged interaction between the participants. I felt like the presenters were very knowledgeable about the points they were trying to get across. They were very approachable."

"The motivational interviewing helped me a lot to find out what each individual's needs are. You know, to help people promote their own self-efficacy, and guide me in how to better serve people, and how to walk with them."

"Going through the process was really long. A lot of people were having a hard time with it, including myself. I think it's because there were so many people who were certifying at once and OHA had to make sure that we all had past background checks and things like that, and so 30 days became about 7 months."

"Their background checks department is pretty lengthy, so that's pretty frustrating for a lot of folks."

- **Rigid background checks**, which were confusing, lengthy, and stressful
- **High cost of training and wait time for scholarships**
- **Need to travel long distances to trainings**, especially for participants working in rural areas

Participants certified through MHACBO mentioned **required time in recovery is too long**.

Participants offered **suggestions** to improve the certification and renewal process, such as offering more online trainings, simplifying the background check application process, and supporting job search activities.

Daily Work Successes, Challenges, and Connections to Other Systems

Participants were quick to point out that there is **"no typical day"** in their work. They described a variety of day to day tasks that they are responsible for, which were outlined in the Participant Background section on page 2. Participants acknowledged that much of their work is centered on being responsive and adaptable to the needs of people receiving services. Most importantly, participants sit with individuals to just "be" with them and listen to the needs of those they are working with and supporting. Often participants shared their personal stories to build trust and rapport.

In addition to listening and sharing, participants said that a large part of their day might be spent in the car driving people to and from appointments and on other errands (e.g., grocery shopping) while also "modeling advocacy, question-asking." Supporting people during medical appointments or accessing social services (e.g., OHP, housing vouchers, food stamps) through other systems also provides both the opportunity to build rapport and improve self-advocacy and autonomy skills.

Participants described the extensive **outreach** they do in their work which included connecting with new people and people already receiving services and networking with other organizations and systems. Outreach is often done in person and includes going to outdoor locations where people tend to congregate (i.e., parks, parking lots, bottle drops, the boardwalk) and at healthcare, treatment and recovery, and resource centers. In addition to recruiting in-person, participants described networking with other organizations and systems to create referral pathways. They also described the outreach they do at community events (e.g., fun runs, pow wows, etc.), posting flyers and using social media.

Participants who held leadership roles described their responsibilities in their organization to perform administrative tasks and grant writing; provide peer supervision and mentorship; and develop and facilitate trainings. Several described the work they do to develop and retain a strong workforce through advocacy efforts and expand their service reach (e.g., developing new resource centers). Participants in leadership positions also described the networking they do with other systems where they teach about and advocate for this work. Additionally, some described the leadership positions they hold on local and state boards and

"You have to be very adaptable in this business. If you're not, you're probably doing the wrong thing. Because, as I say, especially with what I specifically do, there is no typical day."

"It just depends. It could be from taking women to court, to DHS appointments, doctor's appointments, grocery shopping, just anything that they need help with that supports their recovery."

"Usually, what I do to reach people is I just try to connect with them based on empathy, vulnerability, and meeting them where they're at. That's usually how I do that."

"I'm in leadership at [Org. name] and I'm a senior director. I'm considered a thought leader there. I bring the voice of people with lived experience to the decision making for the governments of the organization."

"All these agencies have our information, and that's the way we're doing outreach right now. We do outreach through other agencies, where people are coming to them anyway. They give the information that we provide them so that they can come to us."

advisory councils and committees where they *"bring the voice of people with lived experience to decision making."*

Participants shared a wide range of **success stories** from receiving positive feedback from people receiving peer services to stories of total life transformations. For example, one participant shared a story of a person saying *"Wow! You really understand me. You get me!".* Other participants shared stories of life transformations, including people who:

- Obtained and sustained housing or other basic resources
- Reduced or quit using drugs or alcohol
- Completed certifications and trainings
- Obtained employment
- Regained custody of their children

Some participants described success in training other peer support specialists. Other participants described their own personal growth as a success story describing how this work has challenged their belief system, broadening their understanding of recovery. Finally, some participants described systems transformations as important success stories. One example provided was from a residential treatment center that reduced criminal justice system involvement with people receiving services. Others shared stories about being asked to represent peers at critical decision-making tables and being valued and welcomed at appointments.

Participants described several personal and interpersonal-related **challenges** they face in their daily work. Participants described challenges related to their lived experiences and working in situations that can be re-traumatizing for them. These challenges were exacerbated for some who felt that they were not provided with adequate systems-level resources (e.g., pay and health insurance) to deal with these situations well. Some described challenging situations with people who were aggressive, unkind, or suicidal. Participants shared that many system-level challenges complicated the personal and interpersonal challenges faced in their daily work. System-level challenges are discussed in the following section.

"One of the successes around that specifically was me just honoring the path of where that person was; not pushing my own beliefs around what recovery looks like, but just being with that person in their definition of recovery, honoring that and still allowing for that family to get into housing, regardless of what traditional recovery pathway was being dictated and still is in a lot of ways."

"I've seen some amazing transformations… One of my biggest success stories is a guy that his whole life, he's been in and out of jail… When I met him at the jail, he had a baby on the way. He came out, went into one of our transitional houses. He's been sober now almost nine months. He's moved out. He got a full-time job. He's got a newborn baby. He just got married, and he's been successful."

"Recently a person, they're very angry. They're just a little bit wound up, so it's a little bit challenging because I have lived experiences. I have a life of trauma of my own, even though I live my life well, sometimes when that person is really riled up and ignited, pounding their hand on the desk and everything, that is a little bit challenging for me.."

"Yes, for sure. Especially with my organization, we are very diverse. I think we're all different colors. We all have different religions and different sexual orientations. Yeah. It's very diverse."

Workforce

Participants shared their overall views on workforce diversity, retention, challenges, and suggestions for improvements.

Diversity

Participants shared mixed experiences with their workforce reflecting the demographics of the communities they serve. Some reported that the workforce had diverse representation. These participants specifically mentioned adequate representation related to race, ethnicity, religion, sexual orientation, and language. Some participants reported that representation in certain populations could be improved, and several participants mentioned the importance of

cultural competency trainings to bridge cultural gaps. Some participants reported the workforce lacked diversity and expressed a desire to increase diversity to serve specific populations. **Below are the communities that participants noted as underrepresented in their own words**:

- Native American
- People of color (POC)
- Hispanic / Latinx
- Asian American
- Pacific Islander
- Russian, Ukraine
- Kurdish
- Refugees
- Immigrants
- People with disabilities (physical, behavioral, hearing impaired, sight impaired)
- Religious-specific
- Youth
- LGBTQ+ (specifically gay men)
- Men

Participants shared mixed experiences about whether people have access to someone who speaks their preferred language and identifies with and understands their culture. Some participants reported adequate language and cultural matches and they have the support to find a solution if needed. Most participants felt language was a big issue and did not think they could serve non-English speakers at their organization. A few participants reported that language and cultural matches were not relevant because they *"give the same services to whomever. It has nothing to do with color, creed, sexual preference, any of that."*

Retention

Most participants reported experiencing high turnover in their organizations. Participants described several reasons that lead to turnover within the peer-delivered workforce, including:

- Re-experiencing past trauma at work
- Not provided with tools / resources to adequately address own past trauma
- Lack of respect within the organization (tokenism) and outside (stigma)
- Lack of role definition and scope of work
- Low wages with no or minimal benefits, including physical and mental health care
- Relapse, overdose, and suicide

Some participants noted that the lack of opportunity in the peer workforce also results in people leaving to explore other opportunities (e.g., college, other jobs), people using peer-delivered services as a growth opportunity to go into other professions (e.g., counseling), or people getting promoted outside the workforce. Some participants offered ways to encourage retention including implementing better interview and screening questions to improve fit and offering better wages, benefits, and opportunities for career growth within the workforce.

"I just wish we had more bi-lingual people, and not only in Spanish but other languages, as well."

"I feel like if there were more LGBTQ+ people in the community, who were peers or people of Latina or African American descent, I think that would have a bigger impact on the community… I don't feel like it's equal. I don't feel like there's an equal representation of everything."

"I would say [language diversity is] something that does not have enough support. Our training is not offered in Spanish, for instance. That's something we tried to get funding for and got denied. If there's a lot of additional support in that area, that's absolutely needed."

"People who I care about who have gone very backwards in their own recovery because of not having the support to carry the other heavy stories that they're being asked to help carry."

"The stigma around substance use, and this idea that we can only help people if they're willing to get completely clean and off of everything. That's a really set-in-stone mindset, and it's difficult to get people to see the benefit of helping people, whether they're using or not."

Few participants reported experiencing high retention in their programs. Participant who did note high retention, also expressed understanding the reasons peers leave the workforce, citing difficulty of the work leading to compassion fatigue and burnout.

Challenges

Participants were asked about the major challenges impacting the peer-delivered service workforce in Oregon. Participants described a variety of challenges, including:

- **Lack of understanding of peer role among collaborating providers and other non-peer staff** leading to tokenism, inconsistency in role definition, and lack of integration into organizations
- **Inadequate compensation and opportunities for career growth**, including limited benefits and lack of union for support
- **High turnover rates** from lack of support, trauma, and burnout
- **Gaps in trainings on important topics**, especially trainings focused on equity and diversity
- **Limited services available to support people**, specifically treatment and housing
- **Limited accessibility of services for people**, specifically individuals in jails, prisons, hospitals after an overdose, and rural areas
- **Stigma associated with addiction**, especially in organizations driven by a medical model
- **Limited funding sources and payment models**, including lack of funding, funder priorities driving services rather than people's needs, and reimbursable services not aligning with peer service model. Participants also noted competition for scarce resources can lead to division among peer service providers.
- **Application and certification barriers**, including cost, barriers due to criminal histories, and variation in training requirements by certification type and certification body

One participant who worked at a peer-run organization mentioned the lack of trust within non-per-run organizations in peers' abilities to "*be competent professionals to run organizations*."

Suggestions

Participants were asked what suggestions they have for maintaining and improving the peer-delivered service workforce in Oregon. Many of the suggestions align with challenges participants mentioned throughout the interviews. Suggestions included:

"Part of your job is to relive and re-count your story, your lived experience, but not necessarily having the tools and techniques to do so."

"We had plenty of folks in the beginning who wanted to do this job, but people either didn't know how to utilize them—or they were abusing them by having them do work they weren't supposed to be doing—like medical work billable hours and just kind of being exploited."

"It's very difficult work and it's a difficult job to leave at work. As with any who work in mental health of any sort, it's difficult to put down. It can be weighing on some people. For the people who can handle that, there's a very large retention. For the people who are easily allowing themselves to be burned out, there are a lot of people who aren't retained."

"The career ladder sucks. If you want to be a peer support, the wages don't pay you high enough, and if you want to get a better wage, you have to lose the fidelity of a peer and go to a CADC or become a clinician.

"We need to have more peer leadership roles where their career ladder can go. I think that peers need to have peer supervisors, not clinical oversight."

"We deserve to be paid a lot because we give a lot and we put in a lot."

- **Developing a sustainable workforce model**, including appropriate job support, compensation, benefits, peer service delivery model fidelity, and growth opportunities
- **Increasing funding opportunities**, including payment models that align with peer services and scope of work
- **Increasing support for burnout prevention**, specifically support for compassion fatigue, vicarious trauma, and appropriate supervision
- **Supporting connections between peers across the state**, including encouraging a more unified voice as peer service providers, and building on MHAAO's Peer Support for Peer Support Specialists
- **Increasing awareness, understanding, and value of peer-delivered services** within organizations and health authorities
- **Offering more relevant trainings**, which are centrally advertised and easy to access
- **Streamline certification and renewal process**, including easier processes, shorter turnaround time, improved communication about application status, and more appropriate background checks
- **Supporting greater access to peer-delivered services**, including increased locations and hours to receive services and providing more neighborhood outreach activities that strengthen place-based natural support systems

"I think policies and procedures need to be adapted across the system to alleviate some of this re-traumatization of not only the people who are doing peer support mentorship, but also the providers who don't identify as peer support, like clinicians, social workers, case managers, et cetera, doing more of the same"

"Payment funding streams and Medicaid resources are very rigid in how they operate and how they're disbursed and what they can be used for. Their rates alone are horrible. They're not even livable wages, even for traditional providers. Those payment methods are very limited… Those certain amounts don't allow for people in those roles—whether they're peer support or traditional providers—to really maintain a livelihood unless they're getting more and more and more units. More and more units take away from quality of service and push for quantity to survive. That's where the rigidity and lack of flexibility limits the wellness and support that people are offered."

"Peers are not set up to be paid for the medical model… it gets into an ethical issue, too, of can we fudge the system and use peers as caseworkers? But then you end up having peers doing things they're not supposed to be doing. Or they weren't hired to be doing. We're not hired to answer phones. We're not hired to do things like admin things."

Payment Models

When participants were asked about payment models used by their organizations, many were unsure or expressed a lack of understanding about funding sources. Most participants aware of the payment models reported that peer-delivered services were supported by blended funding, which included fee-for-services, Medicaid billing, and grant-based or contract-based work. Few participants reported services only being supported under one mechanism, such as grant- or contact-based only or Medicaid billing only. One participant received funding through training sign-up costs.

Participants noted several **barriers related to payment models**, such as

- **Contract or grant requirements driving the work** (often with different requirements), instead of people's need
- **Erratic funding** and no staff time to work on grants
- **Complexities of Medicaid billing**, including medical model of reimbursement per encounter not aligned with peer services model; not allowing all peer services to be billable; difficulty of writing accurate clinical notes; reimbursement rates are too low; lack of funding for outreach

Participants provided several **suggestions to improve payment options**, including:

- **Address inadequate reimbursement rates**

- **Encourage collaboration and not competition between services agencies**, including sharing resources and funding
- **Support flexible revenue**, which allows billing outreach and other needed services to Medicaid

Impacts of COVID-19

Participants shared the ways in which COVID-19 has impacted peer- delivered services in Oregon. Some participants identified **negative changes** that most frequently related to the challenges of remote work, such as limited or no in-person interactions with people receiving services or other staff, inability to transport people, and participants and people receiving services having trouble utilizing technology. Several participants noted that people receiving services often do not have access to phones or internet, or do not feel comfortable using technology to communicate – especially individuals experiencing homelessness or those experiencing paranoid thoughts. Participants reported that people receiving services were more stressed, and that the inability to meet in person was a major challenge because interactions were less personal, virtual meetings were not always effective, and feelings of isolation were common for them and those they serve. Participants also reported increased personal stress due to COVID-19, which was impacting their own health and recovery. Other negative experiences included increased workloads, project delays, limited service availability (e.g., closures or changes in hours, not being allowed to attend appointments with people, paused outreach, staffing decreases), and changing priorities to address COVID-19 concerns.

Some participants described **positive changes** in their work as a result of COVID-19, such as expanding service areas, expanding services (e.g., self-care, suicide prevention, increased number of groups and telehealth options), and increased opportunities for connections with new people in need of services (e.g., people with disabilities).

Participants reported **changing the supports provided to people they serve during COVID-19**. Participants described being creative about maintaining connections, such as attending virtual meetings with people, dropping off food boxes on people's porches, and distributing syringes out of their car trunks. Some participants reported a refocus to ensure people's basic needs were met, increasing check-in frequency and technology use, and collaborating with other agencies more frequently. Participants also reported **changing supports received from their organization during COVID-19**. For example, many participants shared that organizations have increased focus on self-care, including encouraging staff to take time off, increasing check-ins with supervisors, and providing trainings on self-care techniques. Some participants reported being provided paid for an hour of self-care during the workday. Other participants reported receiving additional trainings on telehealth best practices, new policies, technology, and COVID-19 information (e.g., infection rates, safety practices).

"Face-to-face contact and then not only with clients but then also with my peers—my co-workers—it's devastating to not be around them."

"Everything's virtual now. My work meetings are on Zoom or on the phone. That's the heart of peer-delivered services, is face-to-face and connecting. It's meeting people where they are."

"It's almost like they're ignoring the opioid issue to focus on COVID-19. Opiate issues are just probably going to be worse right now because people are at home, they're sad, and it's anxiety-ridden times."

"COVID has changed the way we think of outpatient care, and it's actually been a blessing to widen our horizon, so to speak."

"It's a game-changer, because as much as I complain about there might be not as many people that can be reached who are really, really vulnerable, there are also some who have been willing and reachable because they prefer not to go into an office."

"Well, we have gotten creative. I have done a drive up and drop, knock and drop. We've done a lot of that to meet their needs. We've gone and got them food boxes, taken it and set it on their porch."

Participants offered **suggestions** for other ways to support the peer-delivered workforce during COVID-19, including providing more wellness resources, increasing accessibility to services for vulnerable groups unable to connect through technology, providing additional funding support for organizations, centralizing COVID-19 resources and notices of places open for services, and increasing trainings (e.g., COVID-19 safety, intersection of mental health and COVID-19, and ways to collaborate during COVID-19).

Conclusion and Recommendations

Participants shared their varied experiences of the certification and renewal process to deliver peer services, their daily work, and their insights about the workforce overall. Peer-delivered services are expanding rapidly and establishing clear and actionable improvement strategies for the workforce to grow and thrive is imperative.

Based on the data shared in this report and relevant literature on peer-delivered services, we recommend that OHA supports the following efforts to sustain the peer-delivered services workforce:

- **Develop ways to address compassion fatigue, vicarious trauma, and burnout**, which lead to high rates of turnover. Require organizations to have adequate supervision models and encourage peer connections across the state, including building on current support models within the peer community, such as **Peer Support for Peer Support Specialists** and the **Peerpocalypse Conference** organized by MHAAO and the **MetroPlus Association of Addiction Peer Professionals (MAAPPs)** monthly meetings at which peers network with each other, learn from guest speakers, and share resources about ways to advocate locally and at the state-level.
- **Advocate for adequate wages, benefits, and growth opportunities within the workforce.** To maintain a growing workforce, wages and other benefits should align with the job's high emotional demand and demonstrate appreciation for required work needed to understand the complex needs of people in which peers serve. Opportunities to move up within the peer workforce are needed to retain and maintain a strong workforce.
- **Encourage ongoing advocacy** to increase awareness and understanding of the value of peer services, and to decrease stigma and discrimination. Share information with communities and organizations about the roles of peers to highlight their importance as integral members of care teams, and to decrease ambiguity about their roles.
- **Support certification and training standards**, which align with peer-delivered services models of support and collaboration, enhance fidelity, and streamline certification processes. Revisit stringent criminal background check standards, which can reduce the workforce and limit job opportunities for qualified candidates. People from underrepresented communities in the peer workforce may have disproportionate rates of arrests, convictions, and incarcerations leading to lack of diversity in the workforce. Criminal background checks could have shorter lookback periods for minor offenses.
- **Address inadequate reimbursement rates and inaccurate coding for peer services** to create sustainable funding opportunities that align with services being delivered.

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Appendix A: Discussion

The most recent census facts (2019) for the state of Oregon show an estimated 4,217,737 in population.[1] Unlike its traditional health worker workforce, Oregon is less racially and ethnically diverse than the United States on average. With 2,834 registered peer-delivered services workers on the Oregon Health Authority's traditional health worker registry and not all registered peers employed, Oregon needs a larger, more diverse peer workforce to successfully cover its large geographic area and population of over four million. Our number of certified family support specialists, youth support specialists, and peer wellness specialists are especially small. Peer-delivered service workers provide critical services in promoting self-directed health, wellness, and recovery across the state.

While peer-delivered services are, at their core, about honoring the value of lived experience, certain life experiences may result in barriers to workforce entry. For example, individuals with extensive and/or more recent legal histories may face difficulty in passing certification or employment background checks. Stringent criminal background check standards can reduce the workforce and limit job opportunities for qualified candidates. People from underrepresented communities in the peer workforce may have disproportionate rates of arrests, convictions, and incarcerations leading to lack of diversity in the workforce. Some join the peer workforce after periods of unemployment or after being denied by other employers due to the presence of a legal history, and may feel like they are "lucky" to get a job. In those cases, some individuals may be less likely to speak up about workplace issues like being asked to work outside of the peer scope of practice. Participants noted that when they are asked to work outside of their role of practice and provide services like case management, their hourly rate remains the same: the lower wage of a peer-delivered services worker.

Although not all workforce members may feel comfortable advocating to their supervisors or organizations, members of the peer-delivered services workforce consistently reiterated the need for role clarification and awareness raising regarding the role and scope of practice for peers. For employers, it is critical to engage in development of job descriptions that promote peer role fidelity and values. To maintain fidelity to the peer role, job descriptions must not include responsibilities and duties that would result in dual-relationships (e.g. role is part-peer support specialist and part-case manager). This causes boundary and scope confusion for the peer worker, employer, and those receiving services.

With state-approved certification training programs only available in eight of Oregon's 36 counties, individuals outside of those eight counties (mainly grouped around population centers) do not have access to training without increased cost and travel. Lodging and transportation can become cost-prohibitive for those trying to enter the peer workforce, especially with trainings ranging between 40 – 80 hours – and sometimes not occurring on consecutive days. Oregon must improve access to continuing education for peer-delivered service providers, including development of culturally-and linguistically-specific peer certification trainings and continuing education opportunities, to decrease barriers to access to certification and workforce entry.

[1] Oregon Census Quickfacts, (n.d.), Retrieved September 28, 2020 from https://www.census.gov/quickfacts/OR

Additionally, increasingly peer-delivered service positions are requiring reliable personal vehicles, drivers' licenses, and the ability to transport others as part of the role. Requiring a personal vehicle creates barriers that may impact workforce members, especially communities of color that may have less access to a vehicle due to racism, wealth and income disparities, and racially discriminatory pricing practices.[2]

Peer-delivered services workers and persons with lived experience need to be involved in all levels of their organizations. The majority of peer workers do not understand how decisions are made within their organization, and how leadership operates. Leadership and advocacy training must be provided to peers to fully engage in discussions that impact the peer workforce – nothing about us, without us! Members of the peer-delivered services workforce and persons with lived experience should be involved in the planning, design, and implementation of policies and practices that impact the peer workforce for a truly integrated workforce. Largely, the workforce reports being uninformed with respect to topics like payment models and how supervisors and management make decisions.

The ambiguity is present both for peers and employers. Employers need to be supported to better understand peer roles, values, and scope of practice. Workforce and employer respondents alike reported uncertainty about payment models and reimbursement pathways for peer-delivered services. At the same time, a clear and distinct need for increased funding opportunities and improved wages were described. It is difficult to advocate for things that are not well understood, and technical assistance should be provided by the state to support the peer-delivered services workforce and employers in becoming empowered to make the best choices for themselves and their organizations with regard to funding.

Payment models, like Medicaid, that require peer support to be included as part of a treatment plan can lead to clinicians removing the element of choice – such a core tenet of peer support. Making peer-delivered services a part of a clinical plan can impact the person-directed nature of peer support. Additionally, restrictions on the type of activities that can be conducted and reimbursed creates parameters around what peer support is and isn't – out of necessity for continued funding, not born out of fidelity to peer practices.

An additional challenge related to funding is that of documentation – called "a necessary evil" by one participant. Billing and documentation can cause scope shifts to occur. The peer field needs standards and increased understanding regarding peer-centric documentation, like collaborative documentation. This is especially key as peer services continue to expand across Oregon, including into spaces that already have existing clinical documentation standards that peers may be expected to comply with. Peer-centric documentation can both satisfy billing requirements and maintain the true scope of the peer worker.

[2] Car Access: National Equity Atlas. (n.d.). Retrieved September 27, 2020, from https://nationalequityatlas.org/indicators/Car_access

Appendix B: Limitations

LIMITATIONS OF THE NEEDS ASSESSMENT

All data collection methods were subject to response bias. Data collection methods and outreach were conducted in English.

Discussion Groups

A limitation of the polling questions was that respondents could only select one response per question, and would need to verbalize further thoughts or comments. Restrictions on the TurningPoint polling software limited the number of possible responses that could be given for each question for participants to select from. Additional potential limitations for all aspects of the discussion groups include group-think or desirability biases, where participants respond in a way similar to others, or how they think others want them to respond.

Some of the discussion group polling questions were phrased in a way that was confusing to respondents. The discussion groups were also the least well-developed across data collection methods with regard to procedure, instead opting for a flexible approach responsive to the needs of the participants.

Online Surveys

Some survey respondents reported that the peer workforce survey was too long, which resulted in some participants only partially completing the survey. A few of the survey questions were ambiguous, or not structured properly for analysis and evaluation.

Interviews

The phrasing of some of the interview questions were confusing, causing some participants to ask for clarity. The interview guide was adjusted as appropriate to decrease ambiguity. The interview questions were developed primarily for members of the peer-delivered services workforce, resulting in some confusion from participants in leadership or employer roles regarding the questions or phrasing. Interviews were conducted by project staff (themselves members of the peer-delivered services workforce) and researchers from Comagine Health (familiar with but not members of the peer workforce).

Social desirability bias may have impacted participants. Interviewers made efforts to not conduct interviews with persons that they knew prior to the interviews. Demand characteristics also likely impacted the participants, especially those who may have recognized their interviewer or the organization for which they work.

Appendix C: Additional information on methodology

DISCUSSION GROUPS

The Oregon Peer Delivered Services Coalition's annual summit took place in spring 2019 in Pendleton. The no-cost day-long event brought together 60 peers from all parts of the state, with primary representation occurring from eastern Oregon, Portland metropolitan area, mid-Willamette Valley, and southern/Oregon Coast. Participants self-selected into one of the above four groups based on geographic area.

In discussion groups categorized by geography, participants considered four key questions:

- **What** professional development/support **would you like to receive in your role as a peer?**
- **What would you like to see in the** future **for the field of peer delivered services?**
- **What have you** accomplished **through your peer support work?**
- **What** barriers or challenges **have you encountered related to fulfilling your work as a peer?**

The responses provided during the summit discussion groups informed the structure of the guiding conversations in the following discussion groups. To maximize resources and reduce potential participant burden, discussion groups were planned alongside existing events to ensure availability where the peer workforce was congregating (e.g. peer conferences and trainings).

After the initial foundational session with 60 members of the peer workforce representing leaders, employers, culturally-specific programs, and direct peer support staff from across Oregon, key themes were derived to inform the development of polling questions across four categories.

To promote accessibility and acknowledge different comfort levels with public speaking, multiple formats of providing feedback were offered to participants: 1) anonymous virtual polling on the four main areas of professional development, future of peer services, accomplishments, and challenges and barriers; 2) facilitated open group discussion on the four main areas; 3) invitation to share input with discussion group facilitators, either privately in-person or via email or phone.

Participants were instructed on how to use remote clickers to respond to the polling questions (by pressing the corresponding button on the small device that corresponded with their question response) and practiced using a warm-up question, in addition to having project staff available to troubleshoot and provide support for ease of use. A strong majority of participants shared favorable feedback regarding the remote clicker system, and stated how it made the discussion groups more "fun and interactive." Every participant was provided a remote clicker and was able to contribute anonymously. This ensured all were able to share their perspectives in an efficient manner, regardless of desire to speak up in a group.

Furthermore, following every polling question was a facilitated open discussion with the intent to capture all experiences that were not described within the structured polls. Quantitative data was collected from the question responses, which were recorded. During the open discussions, detailed notes were taken on large easel pads and repeated back to confirm accuracy. In this manner, all participants were involved in the transparent note-taking process, which promotes mutuality – a key tenet of peer support. These notes were later reviewed for thematic analysis.

Recognizing the individuality of processing time following discussion, participants were also provided with contact information for project staff, should they wish to provide additional thoughts or feedback. Some elected to share their thoughts with discussion group facilitators immediately following the group events as well.

Foundational discussion group recommendations were analyzed to reveal themes. The primary themes were then utilized to form polling questions for the subsequent discussion groups. Following every poll question was the opportunity to engage in topical open discussion, intended to capture any input not provided through the structured question and response.

Polling questions

What type of peer worker are you? (Participants were instructed to select the type they most closely identified with and felt most accurate in describing their lived experience and role.)

A. Peer Support Specialist – Mental Health
B. Peer Support Specialist – Addiction
C. Youth Support Specialist
D. Family Support Specialist
E. Peer Wellness Specialist
F. Certified Recovery Mentor
G. Certified Gambling Recovery Mentor

What professional development or support would you like to receive in your role as a peer?

A. Continuing education (e.g. ethics, communications, etc)
B. Effective advocacy for living wage
C. Support when my peers aren't doing well
D. Unity and team-building training
E. Career ladder pathways
F. Upper management training to understand peer roles

G. Leadership training in advocacy

What barriers or challenges have you encountered related to fulfilling your role as a peer?

A. No jobs available
B. Local training not available
C. Lack of funding for consumer-run organizations
D. Cost of training and continuing education
E. Peer support not being used fully to its potential
F. Receiving supervision from non-peers
G. Low wages/lack of funding for living wage
H. Fidelity to peer support versus clinical practices (cooptation)

What would you like to see in the future for the field of peer delivered services?

A. Professional organization (i.e. lobby, ethics, standards)
B. Reasonable wages/consistency
C. Background check process simplified
D. More contracting/funding for peer-run organizations
E. Equity for people of color (including more trauma informed cultural training)
F. Recognition that we are non-clinical profession
G. Peers in management/admin/director roles

What have you accomplished through your peer support work?

A. Transformed lives through promoting self-determination and those empowered change systems as well
B. Found community and connection
C. Leadership by example
D. Awareness of cultural perspectives of individuals
E. Stigma reduction
F. Hope

G. Recovery

H. Inclusion

I. Helping others find and identify their own strengths

One-hundred fifty-two members of the peer delivered services workforce from over 20 counties participated in one of four discussion groups between spring 2019 – summer 2020. Discussion groups were offered in eastern Oregon, the Willamette Valley, southern Oregon, and virtually in response to the COVID-19 pandemic. All those who engaged in the discussion groups identified as persons with lived experience who were currently (or had previously been) working in a peer support role, or were making efforts to become employed as a peer. Some of the participants were in positions of leadership and/or employers of peer-delivered services workers.

Due to our community-based participatory approach, the foundational discussion group from which the polling questions were derived served as critical to understanding key themes. Those themes were then presented in the form of polling questions to the next two discussion groups (n=57). The final discussion group was provided online in response to the pandemic, and as such the format was modified to remove the polls as participants would not have access to the clicker devices through which responses were sent to the polling hardware.

KEY INFORMANT INTERVIEWS

A detailed interview guide (below) was developed by MHAAO and Comagine Health for use with the key informant interviews conducted with 28 members of the peer workforce and peer leaders. Outreach was conducted statewide to invite members of the peer-delivered services workforce to participate in the interviews, most of which were one-hour long. All interviews took place over the phone, and participants received $25 gift card as a thank you for their time.
Data consultant Comagine analyzed the qualitative results of the interviews using thematic analysis.

PEER WORKFORCE AND EMPLOYER SURVEYS

Two online surveys were developed from a template provided by the Oregon Health Authority Office of Equity and Inclusion. Many peer-delivered services workforce-specific questions were added to the existing survey template, and questions were modified to be relevant to the work, language, and culture of peers.

Project staff conducted outreach to peer leaders, employers, and member of the peer-delivered services workforce to request input on the survey questions. The Oregon Peer Delivered Services Coalition Steering Committee and Advisory and Evaluation Committee also provided feedback on the design of the surveys, as well OHA's Office of Equity and Inclusion staff.

Once the surveys were completed in August 2019, Office of Equity and Inclusion staff launched the surveys within their SurveyGizmo online platform. At that point, needs assessment project staff created flyers for each survey and conducted extensive outreach regarding the availability of the surveys. Outreach was done to leaders and employers of the peer-delivered services workforce, peer workforce members, organizations providing healthcare, relevant list servs/mailing lists, peer-run organizations, and other stakeholders. Multiple organizations and groups shared the survey flyers and outreach messages, with a combined estimated reach in the thousands.

Data consultant Comagine Health analyzed the workforce and employer surveys and provided the results, available in appendices H and I.

Appendix D: Key Informant Interview Guide

MHAAO Peer Support Worker Interview Guide

[Greet person and briefly introduce self.]

Background: This project is being led by two groups. The first is a peer-run, community-based nonprofit called the Mental Health & Addiction Association of Oregon, or MHAAO. The second group is a statewide coalition focused on developing the peer workforce, called the Oregon Peer Delivered Services Coalition (OPDSCo). OPDSCo is a program of MHAAO and has received money from the Oregon State Office of Equity & Inclusion to do a survey and interviews on what peer support workers need to help them do their jobs. Comagine Health is providing support to conduct these interviews. Comagine Health received funding from Oregon Health Authority's Injury and Violence Prevention Program (IVPP) as part of the Centers for Disease Control and Prevention (CDC) Overdose Data to Action grant.

Peer support workers play a key role in the workforce. To better understand the needs of peer support workers, this project includes interviews, an online survey, and in-person discussion groups. We are interested in learning more about the role of Peer Support Specialists (including Certified Recovery Mentors), Peer Wellness Specialists, Family Support Specialists, and Youth Support Specialists. We'll also briefly discuss COVID 19 and its impact on your work. This project will allow peer workers across the state to share feedback on their jobs.

This work will increase the understanding of the Oregon Health Authority, the Oregon Peer Delivered Services Coalition (OPDSCo), the Mental Health & Addiction Association of Oregon (MHAAO) and others. This will support our workforce and keep our workforce healthy and robust.

Interview purpose: The purpose of this interview is to better understand the needs of the peer workforce in Oregon. As a key member of the peer community, we are grateful for your time and the experience you share throughout this interview. This interview should take 45 - 60 minutes. You will receive a $25 gift card to Amazon for participating.

We will use the information you provide to improve peer delivered services across Oregon. We will do this through advocacy and education.

Note on confidentiality: Interview themes will be included in our final report. We will not share your responses word-for-word or link your identity with your responses. Also, please try to avoid using your name or the name of your colleagues or clients to ensure confidentiality.

With your permission, interviews will be recorded to ensure accuracy of notes. Recordings will not be shared. Is it OK if I record the interview? [If no, do not record interview. Take detailed notes.]

Thank you so much for your time and willingness to participate in this interview.

Any questions before we begin?

OK, I'll turn on the recorder and we'll get started.

Background

1. I would like to start by getting to know you a little better.
a. What organization do you work for, if any? b. What is the goal of the organization? c. How long has this organization been operating? d. What services does this organization provide? e. How do you define your organization/community/service area?
2. Now let's talk about your role.
a. What certification related to peer work do you have? i. *Probe:* You could be a Peer Support Specialist, Certified Recovery Mentor, Peer Wellness Specialist, Family Support Specialist, or Youth Support Specialist. b. How long have you been working in peer delivered services? In what capacity?

Certification and Training

3. Next, Let's talk about peer certification and training.
a. Could you tell me about your experience becoming certified as peer specialist? b. What trainings, if any, were most helpful? c. What trainings, if any, were least helpful? d. Good things about that process? e. What barriers were there, if any, to getting certified? f. Can you describe how the certification *renewal* process has been for you?

Activities

4. Now I'd like to hear about your daily work as a peer specialist. When I ask you these questions please think about your work before COVID 19.

    a. Could you take me through a typical day in your work as a peer?

    b. What outreach activities do you do to reach people to engage in peer-delivered services?

    c. What approaches do you use to reach people?

    d. What places do you go?

    e. Are there any additional places to reach people that you think would be helpful? (e.g., places in the community, places in health care settings)

    f. Can you provide an example of a success story of a peer you've worked with?

    g. Tell me about a time when you experienced challenges working with a peer?

5. We're curious to learn about your connection to other systems as a peer support specialist.

    a. Could you tell me about your experience working with the healthcare system? (Could be physicians or pain specialists).

        a. What type of contact have you had?

        b. Any barriers?

        c. Anything you'd like to change about this relationship?

    b. Could you tell me about your experience working with the social service system? (Could be caseworkers or social workers)

        a. What type of contact have you had?

        b. Any barriers?

        c. Anything you'd like to change about this relationship?

    c. Could you tell me about your experience working with community corrections?

        a. What type of contact have you had?

        b. Any barriers?

        c. Anything you'd like to change about this relationship?

6. We're interested to learn how your work has changed during the COVID-19 (or coronavirus) outbreak.

a. What parts of your workday, if any, have changed during the COVID-19 outbreak?
b. How are you continuing to provide support to the peers you work with during this time?
c. What additional challenges, if any, do you face during the COVID-19 outbreak related to providing peer support?
d. How, if at all, did your relationships with the peers you provide support to change during this time?
e. What additional supports, if any, have you been provided by your organization to continue to do your work during the COVID-19 outbreak?
f. Any additional trainings that you received from your agency as a result of COVID-19?
g. What additional technologies, if any, did your organization use during COVID-19? How did it go?
h. What do you think could be done differently by your organization or the community to help support your work during this time?

Workforce

7. Let's talk about workforce.

a. Do you feel that the Peer Delivered Services (PDS) workforce reflects the diversity of those served with respect to culture and language?
b. Do peers seeking supports have access to someone who speaks their preferred language and identifies with/understands their culture?
c. What communities, if any, are underrepresented in the peer workforce?
    i. This could be rural, non-driver, communities of color, LBGTQ+, youth or others?
d. Please share any observations you have about the retention or turnover of employed peer workers in Oregon.

Payment

8. I'd love to hear about payments and reimbursements for peer support work. Is this something that you feel comfortable speaking to?
a. What existing payment models does your organization use (if relevant)? b. What barriers do you see related to accessing payment resources like Medicaid or other public funding streams? c. What current discussions and recommendations about future payment models are you aware of?

Closing

9. Thanks so much for all the information so far. I'd like to hear a few final thoughts then we'll be done.
a. What are the major issues currently faced related to Peer-delivered services (PDS) in Oregon? b. If you could change one thing about how peer support operates in Oregon, what would it be? c. Any other significant new developments in peer support in Oregon you'd like to tell us about? d. Is there anything else you would like to add? e. Are there other people you think we should talk to?

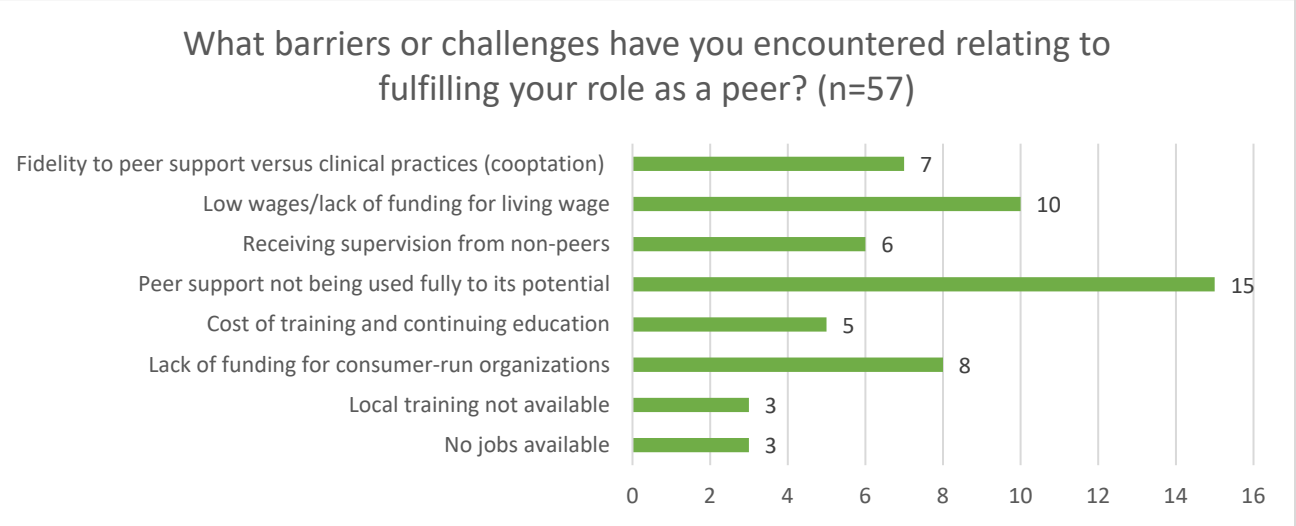
Close: Thank you very much for your time. Your thoughts will be very helpful to our work. We will complete this project and report within the next 6 months or so. At that time, would you like to receive a copy of the report? Thank you again.

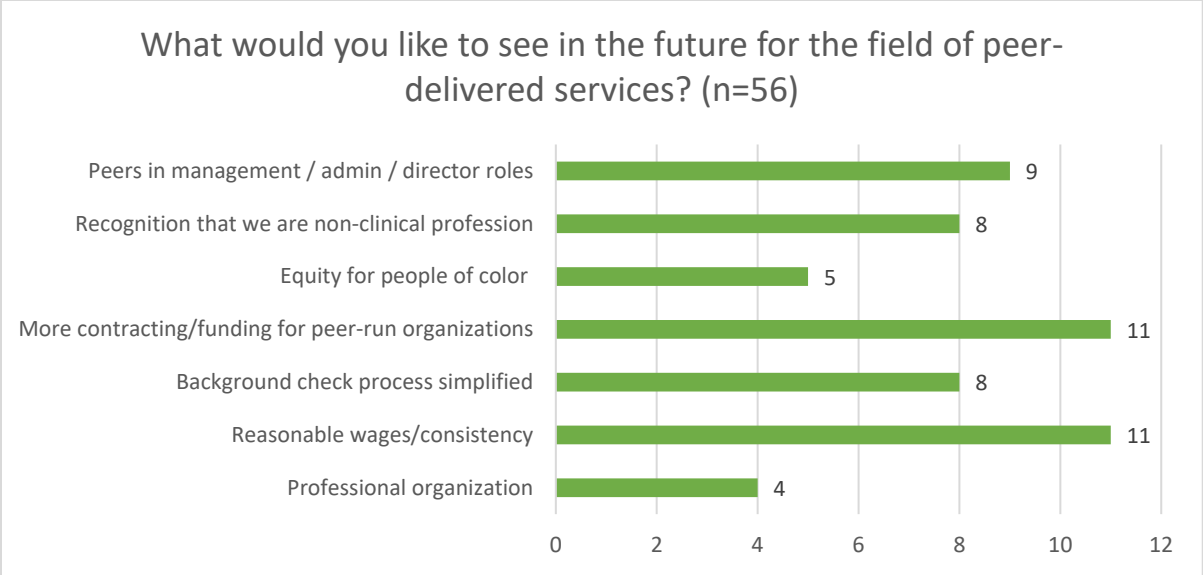
I will send you the $25 gift card from Amazon electronically. Would you prefer I email or text the gift card to you? [Confirm email / phone number are accurate; Add preference to tracking tab]

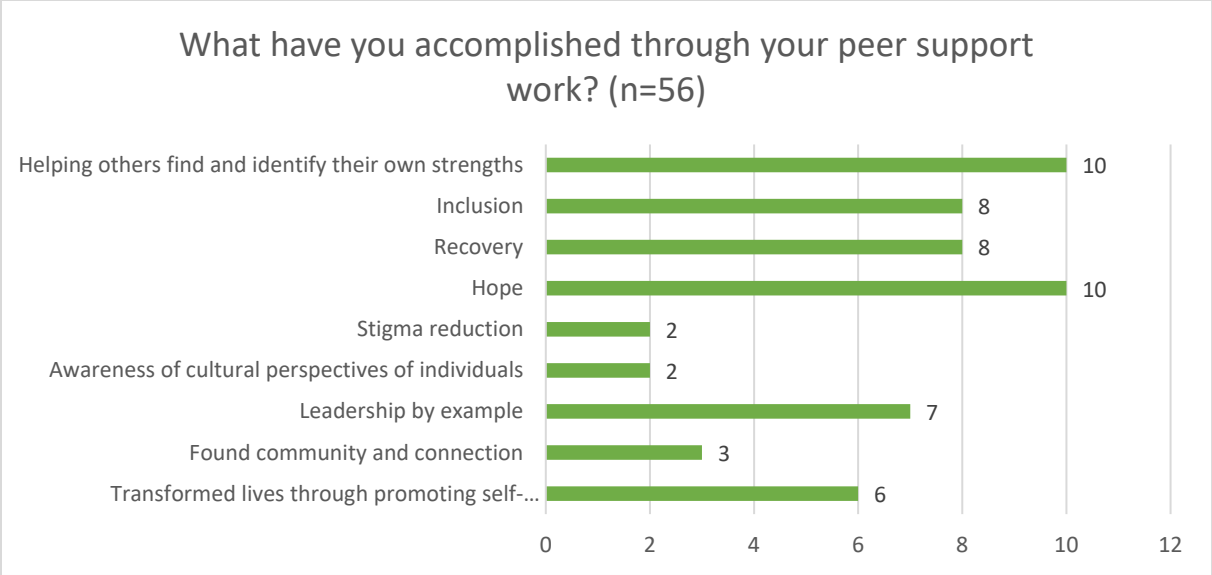
[share business card and availability for follow up, questions, or concerns as needed]

Appendix E: Discussion group polling results

Polling Question Results




What would you like to see in the future for the field of peer-delivered services? (n=56)
Peers in management / admin / director roles
9
Recognition that we are non-clinical profession
8
Equity for people of color
5
More contracting/funding for peer-run organizations
11
Background check process simplified
8
Reasonable wages/consistency
11
Professional organization
4
0
2
4
6
8
10
12


What have you accomplished through your peer support work? (n=56)
Helping others find and identify their own strengths
10
Inclusion
8
Recovery
8
Hope
10
Stigma reduction
2
Awareness of cultural perspectives of individuals
2
Leadership by example
7
Found community and connection
3
Transformed lives through promoting self-...
6
0
2
4
6
8
10
12

Appendix F: Peer-delivered services workforce survey

Welcome to the Oregon Peer Delivered Services Workforce Assessment being conducted by the Mental Health & Addiction Association of Oregon (MHAAO) and Oregon Peer Delivered Services Coalition (OPDSCo) in collaboration with the Oregon Health Authority's Office of Equity & Inclusion (OEI)!

Your work is so important and your experiences and opinions will help influence the future of peer support in Oregon.

Thank you for your interest and support with this effort.

Background: The Oregon Peer Delivered Services Coalition (OPDSCo) is a statewide consumer network focused on workforce development for peers across the state. We bring together individuals and agencies vested in the successful delivery of peer practices and the advancement of the peer workforce statewide. OPDSCo is led by a Steering Committee composed of peer leaders and advocates from across Oregon.

Mental Health & Addiction Association of Oregon is a peer-run, community-based nonprofit. Through support from the State Office of Equity & Inclusion, MHAAO and OPDSCo are conducting a statewide peer workforce needs assessment.

Persons with lived experience play an important role in the workforce and in supporting recovery and self-directed whole health outcomes. Through the Oregon Health Authority, peer workers can become state-approved as Traditional Health Workers (THWs). There are 5 different types of Traditional Health Worker as defined by the Oregon Health Authority. Two of the five types are specific to the peer workforce: Peer Support Specialist (PSS) and Peer Wellness Specialist (PWS). Both worker types have numerous sub-types in line with the lived experience of the PSS or PWS (e.g. mental health, addictions, family support, youth, etc). The PSS and PWS have two specific sub-types of Family Support Specialist and Youth Support Specialist, within which both may work in mental health, addiction, and other peer-related capacities related to their lived experience.

Please visit https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx to learn more.

Survey purpose: The purpose of this survey is to collect data on the peer workforce in Oregon and inform a needs assessment on the role of those working within peer delivered services as Peer Support Specialists (including Certified Recovery Mentors) and Peer Wellness Specialists, inclusive of all sub-types. This survey will enable peer workers across the state to share feedback and information on what their jobs look like and how to improve support of the peer workforce.

We hope to be able to use the information that you provide to further peer delivered services across Oregon through advocacy, education, awareness-raising, and communications. This needs assessment will support the Oregon Health Authority, Oregon Peer Delivered Services Coalition, partners, and others statewide to better support our workforce and keep our workforce healthy and robust. This survey will help identify and meet the needs of workers now and in the future.

What can I expect from the survey? Depending on how detailed your responses are, we estimate this survey will take between 15 – 30 minutes. You may save and return to the survey at any time. There are 8 categories of questions within the survey:

1) Certification and Peer Worker Type
2) Workload

3) Employment
4) Current Workplace
5) Workplace Attitudes
6) Supervision
7) Medicaid and Payment Models
8) Pay and Benefits
9) Culturally and Linguistically Appropriate Services

Finally, there were will be optional demographic questions that will not be connected to your survey responses.

How will results of this survey be used? Results of this survey will be used to inform a statewide assessment on the Oregon peer workforce. Results from this survey will be combined with other data collection activities (e.g. discussion groups and key informant interviews) to create a report for the Oregon Office of Equity & Inclusion that outlines opportunities, challenges, barriers, and recommendations for improving Peer Support Specialist and Peer Wellness Specialist integration in the State of Oregon. This report, once completed, will be widely shared in addition to being available online.

Will my identity be shared or connected to my responses? No. This survey is completely anonymous. All results will be reported in the aggregate (individual responses will be combined and shared on the whole) and your individual responses will remain confidential. At the end of the survey, you will have the option to enter your email address if you would like to be added to the Oregon Peer Delivered Services Coalition mailing list. Your email will not be connected with your survey responses.

Your participation is entirely voluntary and you can withdraw at any time if you would no longer like to participate in the survey.

Who do I contact if I have questions about this survey? Please contact Adrienne Scavera, Director of Training and Outreach with MHAAO, at ascavera@mhaoforegon.org

Your participation in this survey is greatly appreciated.

By clicking "next", you agree to participate in this survey

CERTIFICATION AND PEER WORKER TYPE

1. What type of peer worker are you? Please select the type that you most closely identify with and work primarily within in your peer role. Individuals working within peer delivered services must have the lived experience that qualifies them to do this work.
   - Peer Support Specialist – Mental Health
   - Peer Support Specialist - Addictions
   - Peer Support Specialist – Youth Support Specialist
   - Peer Support Specialist – Family Support Specialist
   - Peer Wellness Specialist – Mental Health
   - Peer Wellness Specialist – Youth Support Specialist
   - Peer Wellness Specialist – Family Support Specialist
   - Peer Wellness Specialist – Addictions
   - Certified Recovery Mentor – Addictions

- Certified Gambling Recovery Mentor – Addictions

[May select multiple responses]

2. If you are certified, what is your certification type within the Traditional Health Worker registry?
   - Peer Support Specialist – Mental Health
   - Peer Support Specialist - Addictions
   - Peer Support Specialist – Youth Support Specialist
   - Peer Support Specialist – Family Support Specialist
   - Peer Wellness Specialist – Mental Health
   - Peer Wellness Specialist – Addictions
   - Peer Wellness Specialist – Family Support Specialist
   - Peer Wellness Specialist – Youth Support Specialist
   - Certified Recovery Mentor – Addictions (certified through MHACBO)
   - Certified Gambling Recovery Mentor – Addictions (certified through MHACBO)
   - I am not certified [skip to #5]

3. When did you first become certified to work as a [response to #2]?
   - Less than one year ago
   - 1-2 years ago
   - 3-4 years ago
   - 4-5 years ago
   - More than 5 years ago

4. Since becoming certified, how long have you been actively employed under this certification?
   - Less than one year
   - 1-2 years
   - 3-4 years
   - 4-5 years
   - More than 5 years
   - Unemployed

[If no/"I am not certified" to #2]

5. If you are not certified, why not? Please check all that apply.
   - Personal choice
   - Background check concerns
   - Lack of paid opportunities
   - Lack of supportive environments to pursue certification
   - Cost or availability of certification training
   - Paid jobs don't offer the flexibility needed to care for yourself or family
   - Certification lapsed – I was certified but am not any more
   - Other ---------- (short answer)

6. Did you experience any barriers to certification?
   - Yes

- No [Skip to #7]

[If "yes" to #6]

6a. What barriers did you experience when trying to become certified? _____(short answer)

WORKLOAD

7. How many individuals do you typically see per month in your role as a peer worker? _

8. Do you have a waitlist?
   - Yes
   - No [Skip to #9]
   - Don't Know/Unknown [Skip to #9]

[Answer if #8 = "Yes"]

8a. How many people are typically on your waitlist every month? _____

9. Do you ever have to turn away potential individuals who would like to receive peer support services?
   - Yes
   - No [Skip to #10]
   - Don't Know/Unknown [Skip to #10]

[Answer if #9 = "Yes"]

9a. Why do you turn away potential peers/clients? _____

_____

10. When you meet with a peer that you are supporting, about how much time do you typically spend with them per encounter?
    - 30 minutes or less
    - Between 31 minutes – 60 minutes (1 hour)
    - Between 61 minutes – 90 minutes (1.5 hours)
    - Between 91 minutes – 120 minutes (2 hours)
    - Between 121 minutes – 180 minutes (3 hours)
    - More than 3 hours

11. How many hours a week do you typically work?
    - 1-8 hours
    - 9-18 hours
    - 18-24 hours
    - 24-32 hours
    - 32-40 hours
    - Over 40 hours a week

12. How do you feel about the numbers of hours that you currently work each week?
    - I would like to work more hours than I currently do.

- I am satisfied with the number of hours that I work.
- I would like to work less hours than I currently do.

EMPLOYMENT

13. How long have you been working as a *[option selected in #1]* since entering this field, across all previous employers? If you are self-employed, how long have you been self-employed as a *[option selected in #1]*?
    - Less than one year
    - 1-2 years
    - 3-4 years
    - 5-6 years
    - More than 7 years
    - Unemployed
    - I volunteer.

14. To what extent do you work in the following settings?

	Always	Frequently	Sometimes	Never
Community-based organization	○	○	○	○
Individual/family home	○	○	○	○
Clinic	○	○	○	○
Hospital	○	○	○	○
Government agency (e.g., county health department)	○	○	○	○
School	○	○	○	○
Forensic/legal	○	○	○	○
Other (please specify) _____	○	○	○	○

15. Have you experienced any difficulty finding work since becoming a *[option selected in #1]*?
    - ○ Yes
    - ○ No [Skip to #16]
    - ○ Don't know/Unknown [Skip to #16]

[Answer if #15 = "Yes"]

15a. What has made it difficult to find work as a *[option selected in #1]*? _____

_____

16. Since you have joined the peer workforce, what is the total amount of time that you have been unemployed or unable to find peers/clients?
    - ○ Less than 1 month
    - ○ 1-6 months
    - ○ 7-12 months
    - ○ 13-18 months
    - ○ 19-24 months
    - ○ More than 24 months

17. In the time you've been working for your current employer, or since you've been self-employed or volunteering, have your skills been appropriately utilized? "Appropriately utilized" means that you have done work that you are specifically trained to do within the scope of practice for your role as a peer.
    - ○ Yes [Skip to #18]
    - ○ No
    - ○ Don't know/Unknown

    [Answer if #17= "No" or "Don't know"]

    17a. Please list the kind of work you have done that falls outside of your skills or training as a *[option selected in Q1]*. _____

18. Do you believe you have the sufficient skills and support to do your job?
    - ○ Yes [Skip to #19]
    - ○ No
    - ○ Don't know/Unknown [Skip to #19]

    [Answer if #18 = "No"]

    18a. Please list some of the barriers to and/or challenges to obtaining the support and developing the skills necessary to do your job. _____

19. In your area, do you have adequate training opportunities or courses available to develop skills related to your job?
    - ○ Yes
    - ○ No [Skip to #19b]
    - ○ Don't know/Unknown [Skip to #20]

    [Answer if #19 = "Yes"]

    19a. Please list the types of training opportunities or courses that have most helped you develop skills related to your job. _____

    [Answer if #19 = "No"]

    19b. Please list the types of training opportunities or courses that would best help you develop skills related to your job. _____

20. Who is responsible for paying for the continuing education units (CEUs) required to maintain your certification?
    - ○ Self
    - ○ Organization/employer
    - ○ Scholarships
    - ○ Other: _____(short answer)

<u>CURRENT WORKPLACE</u>

21. Approximately how long have you been employed in your current peer job?
    - ○ 1-6 months

- 7-12 months
- 13 – 18 months (1 ½ years)
- 1 ½ years – 2 years
- 2 – 3 years
- 3 – 5 years
- Over 5 years
- Not currently employed

[Option to select up to 3 responses for below Q22]

22. Where do you work? Please check the most accurate selection(s). You may select up to 3 options.
    - Within an organization: Non-Profit
    - Within an organization: For-Profit
    - Clinical Setting
    - Community-based organization
    - Peer-run organization
    - In a Hospital or Institution
    - In the Community
    - Drop-in Center
    - Independently – I work for myself
    - Forensic setting (e.g. jail, court, diversion program)
    - School
    - Other: _____ (short answer)

23. What county or counties do you work in? Please check all that apply.

    Baker
    Benton
    Clackamas
    Clatsop
    Columbia
    Coos
    Crook
    Curry
    Deschutes
    Douglas
    Gilliam
    Grant
    Harney
    Hood River
    Jackson
    Jefferson
    Josephine
    Klamath
    Lake
    Lane

Lincoln
Linn
Malheur
Marion
Morrow
Multnomah
Polk
Sherman
Tillamook
Umatilla
Union
Wallowa
Wasco
Washington
Wheeler
Yamhill

24. In your workplace, how many other peer workers are there (not including yourself)?
    - o I'm the only peer in my work environment.
    - o There is one other peer worker.
    - o 2-3 other peer workers.
    - o 4-5 other peer workers.
    - o 6-7 other peer workers.
    - o 8-10 other peer workers.
    - o 10+ other peer workers.

25. What is your favorite part of your job? _____(short essay)

26. What is your least favorite part of your job? _____(short essay)

27. Are you interested in getting a new job/new employer?
    - o Yes.
    - o I'm thinking about it.
    - o No. [Skip to #28]

[If "Yes" or "I'm thinking about it" to #27]

27a. Why are you interested in getting a new job?
- o Better pay
- o Better benefits
- o Organizational culture
- o Improved Commute
- o More opportunities for advancement elsewhere
- o Management/supervisors
- o Coworkers

- Currently unemployed or volunteering
- Other _____(short answer)

WORKPLACE ATTITUDES

28. Do you feel recognized and valued as a full member of your team?
    - Yes.
    - Sometimes.
    - No.

[If "sometimes" or "no" to #28]

28a. What would help you feel recognized and valued as a full member of your team? _____(short essay)

29. Do you feel there is a career path available to you within your organization?
    - Yes
    - No

[If "yes" to #29]

29a. What career paths are available to you within your organization? _____(short essay)

[If "No" to #29]

29b. If no, why not? _____(short essay)

30. Do you feel valued in your position?
    - Yes
    - No

[If "yes" to #30]

30a. What makes you feel valued in your position? _____(short essay)

[If "no" to #30]

30b. Can you tell us why you do not feel valued in your position? _____ (short essay)

SUPERVISION

31. How often do you receive supervision?
    - More than once a week
    - Once a week
    - Twice a month
    - Once a month
    - Every two months
    - Less frequently than every two months
    - I do not receive supervision.

[If response to #30 was "I do not receive supervision":]

31a. Why don't you receive supervision?

- ○ No one qualified to supervise me.
- ○ I am a volunteer or self-employed.
- ○ No one at my organization has time.
- ○ My peer role is not understood well enough by any staff to serve as my supervisor.
- ○ I don't want supervision.
- ○ I don't know why I do not receive supervision.
- ○ Other: _____

[If response to #30 was anything but I do not receive supervision]

31b. How satisfied are you with the quality and frequency of the supervision you receive?

- ○ Highly satisfied
- ○ Satisfied
- ○ Somewhat satisfied
- ○ Unsatisfied
- ○ Highly unsatisfied

32. What experience does your supervisor have?
    - ○ Peer/lived experience
    - ○ Clinical experience
    - ○ Both
    - ○ Other: _____

33. How well does your direct supervisor understand the role, history, and scope of your worker type (PSS, PWS, CRM, FSS, etc.)?
    - ○ Very well
    - ○ Well
    - ○ Somewhat well
    - ○ Not well at all
    - ○ Not at all
    - ○ I do not know/unsure

MEDICAID AND PAYMENT MODELS

In 2007, the Centers for Medicare & Medicaid Services (CMS) approved coverage of peer support services and directed states to define the training and certification requirements. The Oregon Health Authority then developed a method for approving training programs and certifying peers. As an OHA-approved THW Peer Support Specialist or Peer Wellness Specialist, you are eligible to be reimbursed through Medicaid for your services if you work for an agency that can bill Medicaid, coordinate peer support within the context of a comprehensive, individualized plan of care, and are supervised by a Qualified Mental Health Professional (QMHP).

34. How interested are you in being able to bill insurance or Medicaid for your peer support services?
    - ○ Very interested
    - ○ Somewhat interested

- Not at all interested
- I am not sure

35. Do you find it intimidating to try to bill an insurance company or Medicaid for the peer support services you provide to their clients/members?
    - Very intimidating
    - Somewhat intimidating
    - Not at all intimidating

36. For those who are an Oregon Health Authority-approved peer Traditional Health Worker on the registry, have you successfully billed (through your agency) and been reimbursed by Medicaid for your peer support services?
    - Yes
    - No
    - I am not on the state registry [Skip to #37]

[If "yes" or "no" to #36]

36a. Please briefly tell us about your experience, including successes, any barriers, and challenges you have experienced related to Medicaid or other payment reimbursement for your services. ____ [short essay]

37. Would you be interested in the possibility of being eligible to become an OHA-approved THW Peer Support Specialist or Peer Wellness Specialist and to be directly reimbursed by Medicaid, if that becomes an option in the future?
    - Yes
    - No
    - I'm not sure

[Allow user to select up to 2 options for below question]

38. Which payment reimbursement model(s) do you see as being most beneficial for peer delivered services work?
    - Fee-for-service (FFS) (paid a fee for each service provided from an approved service list)
    - Alternative payment model (APM) (payment other than FFS that is used to coordinate and integrate healthcare services. Provides added incentive payments to give high quality and cost-efficient care.)
    - Values-based payment (VBP) (holds providers accountable for both the cost and the quality of care they deliver. Providers are rewarded financially for delivering better, more cost-effective care, and can be penalized for not meeting targets.)
    - Not sure/unknown
    - Other:_____(short answer)

38a. Please share any other thoughts or comments that you have about payment reimbursement models for peer delivered services. [short essay box]

39. Which funding sources would you be most interested in pursuing should the option be made available? Please rank the below options from 1 – 5, with 1 being "most interested" and 5 being "least interested".
    - Contract with coordinated care organizations (CCOs)
    - Contract or receive grants from state or county
    - Directly bill Medicaid as an individual peer provider
    - Bill Medicaid through a peer-run organization
    - Directly bill private/commercial insurance

PAY AND BENEFITS

40. What are your wages?

    _____ per hour

41. What is your total annual income as a result of your work as a [option selected in Q1]?
    - ○ $10,000 or less
    - ○ $10,001 to $20,000
    - ○ $20,001 to $30,000
    - ○ $30,001 to $40,000
    - ○ $40,001 to $50,000
    - ○ $50,001 or more

42. How satisfied are you with your pay?
    - Not satisfied
    - Somewhat satisfied
    - Satisfied
    - Very Satisfied

43. Do you receive benefits? Check all that apply.
    - I do not receive benefits.
    - Medical
    - Dental
    - Vision
    - Vacation time
    - Retirement: 401k, 403b, etc.
    - Other:_____

44. How satisfied are you with your benefits?
    - Not satisfied
    - Somewhat satisfied
    - Satisfied
    - Very Satisfied

45. Do you get paid time off? Check all that apply.
    - Vacation time
    - Sick time
    - Wellness days
    - Paid volunteer days
    - Holidays
    - Unpaid time off
    - I do not receive time off benefits.

CULTURALLY AND LINGUISTICALLY-SPECIFIC SERVICES

Culturally and linguistically-specific services are intended to improve health equity and reduce disparities by providing services that are respectful of and responsive to the culture, language, practices, needs, and health beliefs of the individuals we serve.

46. Are you able to provide culturally- and linguistically-specific peer support services?
    - ○ Yes [Skip to #47]
    - ○ No
    - ○ Don't Know/Unknown

    [if "no" or "don't know" to #46]

    46a. Do you have the ability to connect with someone within your organization who can provide culturally- and linguistically-specific peer support services?
        - Yes
        - No
        - Don't know/Unknown

47. Please list some of the barriers, challenges, and/or successes you have experienced in providing culturally- and linguistically-specific peer support services. _____

    _____

48. Do the employees in your workplace reflect the diversity of the communities you serve?
        - Yes
        - No
        - Don't know/Unknown

    [if "no" to 48]

    48a. What could be done to promote equity and inclusion and improve the diversity of your workplace?_____[short essay]

Please share any other thoughts, comments, or recommendations that you have regarding the peer workforce in Oregon. _____(short essay)

[disconnect the below response from the other survey questions to ensure anonymity]

Would you like to be added to the Oregon Peer Delivered Services Coalition mailing list to receive emails (typically monthly) with resources, events, and training opportunities relevant to the peer workforce? [box for email address]

REAL+D Questions

The below questions are optional and confidential. You may decline to answer any question(s). Your responses will help to inform the Office of Equity and Inclusion about the diversity of the peer workforce.

49. In your own words, how would you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?

_____

50. Which of the following describes your racial or ethnic identity? *Please check ALL that apply*

American Indian or Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis or First Nation
- ☐ Indigenous Mexican, Central American or South American

Hispanic or Latino/a
- ☐ Hispanic or Latino Central American
- ☐ Hispanic or Latino Mexican
- ☐ Hispanic or Latino South American
- ☐ Other Hispanic or Latino

Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian or Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Micronesian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Black or African American
- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

Middle Eastern/Northern African
- ☐ Northern African
- ☐ Middle Eastern

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

- ☐ Other (please list) _____
- ○ Don't know/Unknown
- ○ Don't want to answer/Decline

51. Please select one racial or ethnic identity that best represents your primary racial or ethnic identity. *Only the response option(s) selected in Q50 will be listed.*

52. What language do you typically prefer to use outside of the home when **speaking** about important matters?

- ○ English
- ○ Spanish
- ○ Chinese
- ○ Vietnamese
- ○ Russian
- ○ Korean
- ○ Other (please specify)
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

53. What language do you typically prefer to use outside of the home when receiving important **written** communications?
    - ○ English
    - ○ Spanish
    - ○ Chinese
    - ○ Vietnamese
    - ○ Russian
    - ○ Korean
    - ○ Other (please specify)
    - ○ Don't Know/Unknown
    - ○ Don't Want to Answer/Decline

54. Do you need a **sign language** interpreter for us to communicate with you?
    - ○ Yes
    - ○ No
    - ○ Don't Know/Unknown
    - ○ Don't Want to Answer/Decline

    [Answer if #54= "Yes"]

    54a. Which type do you need us to communicate with you?
        - ○ ASL - American Sign Language
        - ○ PSE – Pidgin Signed English
        - ○ SEE - Signing Exact English
        - ○ Tactile Interpreting
        - ○ Cued Speech
        - ○ Other sign language (please specify) _____
        - ○ Don't Know/Unknown
        - ○ Don't Want to Answer/Decline

55. When communicating in person with others (such as the doctor's office) do you need a **spoken language** interpreter?
    - ○ Yes
    - ○ No
    - ○ Don't Know/Unknown
    - ○ Don't Want to Answer/Decline

56. How well do you speak English?
- ○ Very Well
- ○ Well
- ○ Not Well
- ○ Not At All
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

57. Are you deaf or do you have serious difficulty hearing?
- ○ Yes
- ○ No
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

[Answer if #57 = "Yes"]

51a. At what age did this condition begin? _____

58. Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?
- ○ Yes
- ○ No
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

[Answer if #58 = "Yes"]

58a. At what age did this condition begin? _____

59. Do you have serious difficulty **walking or climbing stairs**?
- ○ Yes
- ○ No
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

[Answer if #59 = "Yes"]

59a. At what age did this condition begin? _____

60. Do you have difficulty **dressing or bathing**?
- ○ Yes
- ○ No
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

[Answer if #60 = "Yes"]

60a. At what age did this condition begin? _____

61. Because of a **physical, mental, or emotional condition**, do you have serious difficulty:

	Yes	No	Don't Know/ Unknown	Don't Want to Answer/Decline
a. Concentrating, remembering, understanding, or making decisions?	○	○	○	○
b. **Doing errands alone** such as visiting a doctor's office or shopping?	○	○	○	○

[Answer if #61a = "Yes"]

61c. At what age did you begin to have serious difficulty concentrating, remembering, understanding, or making decisions? _____

[Answer if #61b = "Yes"]

61d. At what age did you begin to have serious difficulty **doing errands alone** such as visiting a doctor's office or shopping? _____

62. Does a physical, mental, or emotional condition limit your activities in any way?
- ○ Yes
- ○ No
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

63. What is your age today? _____

Your responses to the questions below will help us find and address health and service differences by sex, gender identity, and sexual orientation. These questions are optional and confidential.

64. What are your preferred pronouns?
- ○ He/Him/His
- ○ She/Her/Hers
- ○ They/Them/Their
- ○ Additional pronouns not listed (please specify): _____
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

65. What sex were you **assigned at birth** on your original birth certificate?
- ○ Female
- ○ Male
- ○ Don't Know/Unknown
- ○ Don't Want to Answer/Decline

66. What is your **current gender identity**? *Select ALL that apply*
- ☐ Female
- ☐ Male
- ☐ Transgender female
- ☐ Transgender male
- ☐ Genderqueer

- ☐ Gender Fluid
- ☐ Gender Expansive
- ☐ Gender Nonconforming
- ☐ Non-Binary
- ☐ Two-Spirit
- ☐ Questioning
- ☐ Additional Category (please specify) _____
- ☐ Don't Know/Unknown
- ☐ Don't Want to Answer/Decline

67. Which of the following best represents how you think of yourself?
    - ○ Straight/Heterosexual
    - ○ Gay
    - ○ Lesbian
    - ○ Bisexual
    - ○ Queer
    - ○ Questioning
    - ○ Additional Category (please specify): _____
    - ○ Don't Know/Unknown
    - ○ Don't Want to Answer/Decline

68. Please provide any additional comments about your experience as a *[option selected in Q1]* below.

_____

Your participation and time are sincerely appreciated. Thank you for the work you do within the Oregon peer workforce!

Appendix G: Employer Survey

Welcome to the Oregon Peer Delivered Services Workforce Assessment being conducted by the Mental Health & Addiction Association of Oregon (MHAAO) and Oregon Peer Delivered Services Coalition (OPDSCo) in collaboration with the Oregon Health Authority's Office of Equity & Inclusion (OEI)!

As an employer, you play a key role in the success of peer delivered services statewide. Your experiences and opinions will help influence the future of peer support in Oregon.

Thank you for your interest and support with this effort.

Background: The Oregon Peer Delivered Services Coalition (OPDSCo) is a statewide consumer network focused on workforce development for peers across the state. We bring together individuals and agencies vested in the successful delivery of peer practices and the advancement of the peer workforce statewide. OPDSCo is led by a Steering Committee composed of peer leaders and advocates from across Oregon.

Mental Health & Addiction Association of Oregon is a peer-run, community-based nonprofit. Through support from the State Office of Equity & Inclusion, MHAAO and OPDSCo are conducting a statewide peer workforce needs assessment.

Persons with lived experience play an important role in the workforce and in supporting recovery and self-directed whole health outcomes. Through the Oregon Health Authority, peer workers can become state-approved as Traditional Health Workers (THWs). There are 5 different types of Traditional Health Worker as defined by the Oregon Health Authority. Two of the five types are specific to the peer workforce: Peer Support Specialist (PSS) and Peer Wellness Specialist (PWS). Both worker types have numerous sub-types in line with the lived experience of the PSS or PWS (e.g. mental health, addictions, family support, youth, etc). The PSS and PWS have two specific sub-types of Family Support Specialist and Youth Support Specialist, within which both may work in mental health, addiction, and other peer-related capacities related to their lived experience.

Please visit https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx to learn more.

Survey purpose: The purpose of this survey is to collect data on employers of the peer workforce in Oregon and inform a needs assessment on the role of those working within peer delivered services as Peer Support Specialists (including Certified Recovery Mentors) and Peer Wellness Specialists, inclusive of all sub-types. This survey will enable employers of peers across the state to share feedback on how to improve support of the peer workforce.

We hope to be able to use the information that you provide to further peer delivered services across Oregon through advocacy, education, awareness-raising, and communications. This needs assessment will support the Oregon Health Authority, Oregon Peer Delivered Services Coalition,

partners, and others statewide to better support our workforce and keep our workforce healthy and robust. This survey will help identify and meet the needs of workers now and in the future.

What can I expect from the survey? Depending on how detailed your responses are, we estimate this survey will take between 8 – 20 minutes. You may save and return to the survey at any time. There are 4 categories of questions within the survey:

1) Basic organizational information
2) Peer delivered services within the workplace
3) Payment models and reimbursement pathways
4) Culturally and linguistically-specific services
5) Barriers, successes, and technical assistance

How will results of this survey be used? Results of this survey will be used to inform a statewide assessment on the Oregon peer workforce. Results from this survey will be combined with other data collection activities (e.g. discussion groups and key informant interviews) to create a report for the Oregon Office of Equity & Inclusion that outlines opportunities, challenges, barriers, and recommendations for improving Peer Support Specialist and Peer Wellness Specialist integration in the State of Oregon. This report, once completed, will be widely shared in addition to being available online.

Will my identity be shared or connected to my responses? No. This survey is anonymous. All results will be reported in the aggregate (individual responses will be combined and shared on the whole) and your individual responses will remain confidential. At the end of the survey, you will have the option to enter your email address if you would like to be added to the Oregon Peer Delivered Services Coalition mailing list. Your email will not be connected with your survey responses.

Your participation is entirely voluntary and you can withdraw at any time if you would no longer like to participate in the survey.

Who do I contact if I have questions about this survey? Please contact Adrienne Scavera, Director of Training and Outreach with MHAAO, at ascavera@mhaoforegon.org

Your participation in this survey is greatly appreciated.

By clicking "next", you agree to participate in this survey

BASIC ORGANIZATIONAL INFORMATION

1. How would you classify your organization? Please check all that apply.
   - Government agency
   - Coordinated care organization

- Hospital or clinic
- School
- Forensic/corrections
- Community-based organization
- Peer-run organization
- Social-service organization
- Mental health or addiction provider
- Non-profit
- For-profit
- Other: _____

2. Please approximate the following numbers for your organization:

TOTAL EMPLOYEES	TOTAL CONTRACTORS	TOTAL VOLUNTEERS

3. What is your organization's approximate annual operating budget?
    - Under $500,000
    - Between $500,000 - $999,999
    - Between $1,000,000 - $4,000,000
    - Between $4,000,001 – $9,999,999
    - Between $10,000,000 - $25,000,000
    - Between $25,000,000 - $75,000,000
    - Between $75,000,001 - $125,000,000
    - Over $125,000,000
    - Unknown.
    - Prefer not to answer.

4. In which counties does your organization provide services? Please check all that apply.
    Baker
    Benton
    Clackamas
    Clatsop
    Columbia
    Coos
    Crook
    Curry
    Deschutes
    Douglas
    Gilliam
    Grant
    Harney

Hood River
Jackson
Jefferson
Josephine
Klamath
Lake
Lane
Lincoln
Linn
Malheur
Marion
Morrow
Multnomah
Polk
Sherman
Tillamook
Umatilla
Union
Wallowa
Wasco
Washington
Wheeler
Yamhill

5. How familiar is your organization with the field of peer delivered services?
    - Not at all familiar
    - Slightly familiar
    - Somewhat familiar
    - Moderately familiar
    - Extremely familiar

6. Does your organization employ peer workers?
- Yes
- No [Skip to #8]
- I am not sure.

PEER DELIVERED SERVICES WITHIN YOUR WORKPLACE

[If "yes" to #6]

7. Which type(s) of peer workers does your organization employ?
- Peer Support Specialist – Mental Health

- Peer Support Specialist - Addictions
- Peer Support Specialist – Youth Support Specialist
- Peer Support Specialist – Family Support Specialist
- Peer Wellness Specialist – Mental Health
- Peer Wellness Specialist – Addictions
- Peer Wellness Specialist – Family Support Specialist
- Peer Wellness Specialist – Youth Support Specialist
- Certified Recovery Mentor – Addictions (certified through MHACBO)
- Certified Gambling Recovery Mentor – Addictions (certified through MHACBO)
- Peer Support Specialist, subtype not known
- Peer Wellness Specialist, subtype not known
- Family Support Specialist, subtype not known
- Youth Support Specialist, subtype not known
- I am not sure [skip to #8]

[For each worker subtype option that is checked, please show the following questions for each type:]

7a. How many persons are employed or contracted with in this position with your organization?:____

7b. What is the total full-time equivalency (FTE) for this peer worker type? : ____

7c. What is the pay range for this position? _____

8. Are you currently contracting with community-based organizations to provide peer delivered services?
   - Yes, we contract with multiple community-based organizations to provide peer support to those we serve.
   - Yes, we contract with one community-based organization to provide peer support services.
   - No.
   - We are a community-based organization that provides peer services. [skip to #10]

9. Would you like to be able to offer peer delivered services to your members/clients/consumers?
   - Yes [Skip to 9a]
   - No [Skip to 9b]
   - I am not sure/undecided [Skip to 9a]
   - We already offer peer delivered services. [Skip to #10]

[If "yes" to #9]

9a. If you aren't currently offering peer delivered services, what barriers are you experiencing to implementation?

[If "no" to #9]

9b. What would your organization need in order to be interested in offering peer delivered service?

10. Has your organization experienced any challenges in hiring and retaining qualified peer delivered service providers?
    - Yes [Go to 10a]
    - No
    - Not sure

[If "yes" to #10]

10a. Please share what challenges you have experienced related to hiring and retaining qualified peer workers. _____[short essay box]

11. How frequently do peer delivered services staff receive supervision?
    - More than once a week
    - Once a week
    - Twice a month
    - Once a month
    - Every two months
    - Less frequently than every two months
    - They do not receive supervision.
    - I am not sure.

12. How are supervisors of peer workers supported to understand the role, scope, and values of peer support positions? Please check all that apply.
    - Supervisors receive relevant training prior to working with peer staff.
    - Supervisors have access to as-needed supervision and technical assistance.
    - Supervisors are provided materials on peer delivered services in Oregon to review.
    - Supervisors of peer workers have experience working within peer roles themselves.
    - Supervisors are not provided any additional or special support.
    - I am not sure.

13. How are your organization's peer positions funded?
    - Medicaid-billable position
    - County grants or contracts
    - State grants or contracts
    - Federal grant
    - General fund
    - Fundraising/endowments
    - Other:_____

- Positions are volunteer

PAYMENT MODELS AND REIMBURSEMENT PATHWAYS

In 2007, the Centers for Medicare & Medicaid Services (CMS) approved coverage of peer support services and directed states to define the training and certification requirements. The Oregon Health Authority then developed a method for approving training programs and certifying peers. Oregon Health Authority-approved Traditional Health Worker Peer Support Specialist or Peer Wellness Specialist are eligible to be reimbursed through Medicaid for their services if they work for an agency that can bill Medicaid, coordinate peer support within the context of a comprehensive, individualized plan of care, and are supervised by a Qualified Mental Health Professional (QMHP). To learn more, please use this link:
https://www.oregon.gov/oha/HSD/OHP/Tools/Enrollment%20and%20billing%20for%20peer-delivered%20services.pdf

14. How interested is your organization in being able to bill insurance or Medicaid for peer support services?
    - Very interested
    - Somewhat interested
    - Not at all interested
    - I am not sure

15. For those who employ Oregon Health Authority-approved peer Traditional Health Workers, has your agency successfully billed and been reimbursed by Medicaid for peer support services?
    - Yes
    - No
    - I am not sure.

[If "yes" or "no" to #15]

15a. Please briefly tell us about your experience, including successes, any barriers, and challenges your organization has experienced related to Medicaid or other payment reimbursement for peer delivered services. ____ [short essay]

[Allow user to select up to 2 options for below question]

16. Which payment reimbursement model(s) do you see as being most beneficial for peer delivered services work?
    - Fee-for-service (FFS) (paid a fee for each service provided from an approved service list)

- Alternative payment model (APM) (payment other than FFS that is used to coordinate and integrate healthcare services. Provides added incentive payments to give high quality and cost-efficient care.)
- Values-based payment (VBP) (holds providers accountable for both the cost and the quality of care they deliver. Providers are rewarded financially for delivering better, more cost-effective care, and can be penalized for not meeting targets.)
- Not sure/unknown
- Other:_____[short answer]

16a. Please share any other thoughts or comments that you have about payment reimbursement models for peer delivered services. [short essay box]

17. Which funding sources would you be most interested in pursuing should the option be made available? Please rank the below options from 1 – 5, with 1 being "most interested" and 5 being "least interested".
    - Contract with coordinated care organizations (CCOs)
    - Contract or receive grants from state or county
    - Contract with peer providers who directly bill Medicaid themselves
    - Bill Medicaid
    - Directly bill private/commercial insurance
    - I am not sure

CULTURALLY AND LINGUISTICALLY-SPECIFIC SERVICES

Culturally and linguistically-specific services are intended to improve health equity and reduce disparities by providing services that are respectful of and responsive to the culture, language, practices, needs, and health beliefs of the individuals we serve.

18. Is your organization able to provide culturally- and linguistically-specific peer support services?

- ○ Yes [Skip to #19]
- ○ No
- ○ Don't Know/Unknown

[if "no" or "don't know" to #18]

18a. Do you have the ability to connect with someone outside of your organization who can provide culturally-and linguistically-specific peer support services?

- Yes
- No
- Don't know/Unknown

19. Please list some of the barriers, challenges, and/or successes your agency has experienced in providing culturally- and linguistically-specific peer support services.

_____

_____

20. Do the employees in your workplace reflect the diversity of the communities you serve?
    - Yes
    - No
    - Don't know/Unknown

[if "no" or "don't know" to #20]

20a. What could be done to promote equity and inclusion and improve the diversity of your workplace?_____[short essay]

BARRIERS, SUCCESSES, AND TECHNICAL ASSISTANCE

21. If you do not currently offer peer delivered services within your workplace, what would you want or need to consider its implementation? _____ [short essay]

22. Please share any barriers to supporting peer traditional health worker positions within your workplace. _____ [short essay]

23. Please share any successes or benefits experienced as a result of having peer positions within your workplace. _____[short essay]

24. Are you interested in learning more about peer delivered services?
    - Yes
    - No [Skip to end]
    - Not sure

[If "yes" or "not sure" to #24]

24a. Which of the following options would you be most interested in receiving? Please check all that apply.
    - One-page informational sheet on peer delivered services
    - One-hour webinar
    - Presentation by consumers/members receiving peer delivered services
    - Two-hour onsite training
    - Visit to a site providing peer delivered services
    - Other: _____

25. Is there any other information that you think it would be important to share about being an employer of members of the peer workforce?

[disconnect the below response from the other survey questions to ensure anonymity]

26. Would you like to be added to the Oregon Peer Delivered Services Coalition mailing list to receive emails (typically monthly) with resources, events, and training opportunities relevant to the peer workforce? [box for email address]

Thank you for your time in filling out this survey.

Appendix H: Peer workforce survey

1. What type of peer worker are you? Please select the type that you most closely identify with and work primarily within in your peer role. Individuals working within peer delivered services must have the lived experience that qualifies them to do this work.
   Note: Due to small numbers in several of the peer-delivered service worker subtype, responses were aggregated based on lived experience into the six following types below.

Peer Worker Type Identification	Count (n=401)	Percent
Peer Support Specialist – Mental Health	157	39%
Certified Recovery Mentor - Addictions	76	19%
Peer Support Specialist - Addictions	61	15%
Family Support Specialist	56	14%
Peer Wellness Specialist – Mental Health	24	5%
Peer Wellness Specialist - Addictions	8	2%
Youth Support Specialist	12	2%
Peer Wellness Specialist – Family Support Specialist	5	1%
Certified Gambling Recovery Mentor - Addictions	2	<1%
Peer Wellness Specialist – Youth Support Specialist	0	0%

Peer Support Type	Count (n = 401)	Percent
Mental Health	157	39%
Addiction	139	34%
Family Support	61	15%
PWS Mental Health	24	5%
Youth Support	12	2%
PWS Addiction	8	2%

2. If you are certified, what is your certification type within the Traditional Health Worker registry? [May select multiple responses]

Response	Count (n = 368)	Percent
Peer Support Specialist - Mental Health	170	46%
Certified Recovery Mentor - Addictions (certified through MHACBO)	122	33%
Peer Support Specialist - Addictions	99	27%
Family Support Specialist	60	16%
Peer Wellness Specialist - Mental Health	45	12%
Peer Wellness Specialist - Addictions	22	6%
Youth Support Specialist	15	4%
Peer Wellness Specialist - Family Support Specialist	5	1%
Certified Gambling Recovery Mentor - Addictions (certified through MHACBO)	5	1%
Peer Wellness Specialist - Youth Support Specialist	3	1%

3. When did you first become certified to work as a [response to #2]?

Response	Count (n = 346)	Percent
3-4 years ago	133	38%
Less than one year ago	87	25%
More than 5 years ago	73	21%
4-5 years ago	53	15%

4. Since becoming certified, how long have you been actively employed under this certification?

Response	Count (n = 354)	Percent
3-4 years	79	22%
Less than one year	75	21%
1-2 years	67	19%
More than 5 years	67	19%
4-5 years	55	16%
Unemployed	11	3%

5. If you are not certified, why not? Please check all that apply.

Response	Count (n = 13)	Percent
Lack of supportive environments to pursue certification	5	38%
Cost or availability of certification training	5	38%
Personal choice	4	31%
Background check concerns	3	23%
Lack of paid opportunities	2	15%
Paid jobs don't offer the flexibility needed to care for yourself or family	1	8%

Other – Themes (bolded) and supporting responses

Do not have a need to be certified

- Board Member -Peer Support Organization
- I'm a cadc but still a peer and work in a peer program.
- not important as i am working part time and part time retired
- Just learning how to become an advocate

Unaware of certification process

- Don't know the process to get certified
- I am just learning about becoming certified recently

In process of completing certification

- Waiting on Oregon Health Authority
- Working on certification
- i have taken the training, haven't applied for certification

Do not meet certification requirements

- I do not have the "required lived experience"
- OHA wanted to much information that i was not able to obtain

COVID impacts

- I am barley getting training due to COVID

Other impacts

- Just released from prison.

6. Did you experience any barriers to certification?

Response	Count (n = 377)	Percent
No	294	78%
Yes	83	22%

a. What barriers did you experience when trying to become certified?

Theme	Count	Supporting Responses
Background checks process	30	▶ Background barriers and collecting all the positive things I did to change my life around from agencies. It's easy to find the bad. ▶ Background check took an extremely long time which caused my employer to delay hiring.
Delays / long wait times for processing	25	▶ bureaucratic glitches and delays ▶ getting email response in a timely manner, about certification
Unclear processes	10	▶ The paperwork for certification was confusing and inconsistent ▶ Confusing renewal process. It took me several attempts to get my recertification complete. Instructions were unclear and inaccessible.
Cost	8	▶ Finding the funds to cover certification training costs. ▶ Without a scholarship from MHAO I wouldn't have been able to afford the training.
Time needed to travel for training	5	▶ The time away from family. The expense of traveling out of town. ▶ Coming from Far Eastern Oregon for training required traveling 958 miles for the 5 One day trainings weekly at a great expense, 2 weeks solid would have been better.
Other	11	▶ Inconvenient training days and times (2) ▶ Technology barriers (2) ▶ Requirement changes (2) ▶ Stigma (1) ▶ Lack of non-English training options (1) ▶ Education credits didn't meet requirements (1) ▶ Other time commitments took priority (1) ▶ Collecting all the needed paperwork (1)

7. How many individuals do you typically see per month in your role as a peer worker?

Metric	Value
Minimum	0
Maximum	500

Mean	29
Median	18

8. Do you have a waitlist?

Response	Count (n = 352)	Percent
No	243	69%
Yes	62	18%
Don't Know/Unknown	47	13%

a. How many people are typically on your waitlist every month?

Metric	Value
Minimum	2
Maximum	527
Mean	22
Median	9

9. Do you ever have to turn away potential individuals who would like to receive peer support services?

Response	Count (n = 348)	Percent
No	217	62%
Yes	81	23%
Don't Know/Unknown	50	14%

a. Why do you turn away potential peers/clients?

Theme	Count	Supporting Responses
Caseload full / at capacity	45	▶ More people wanting the service than we capacity to serve.
Person does not meet requirements for services	19	▶ They don't qualify. ▶ They are unable and/or unwilling to do their part in obtaining sobriety and/or recovery. ▶ If it's not appropriate to my scope of duties
Unable to meet person's needs (e.g., language barriers)	11	▶ Due to lack of facilities offering culturally specific services. In fact, we don't have facilities offering

		recovery services in other languages -- Russian, Vietnamese, Spanish. ▶ Individual's needs are outside my field.
Insurance incompatibility / other insurance issues	5	▶ Because they have private insurance not OHP ▶ Sometimes a peer is not enrolled in SUDS services and I am unable to bill for them
Other	4	▶ Current or past relationships with person (2) ▶ COVID-19 (1) ▶ Do no reject anyone (1)

10. When you meet with a peer that you are supporting, about how much time do you typically spend with them per encounter?

Response	Count (n = 342)	Percent
31 - 60 minutes (1 hour)	169	49%
61 - 90 minutes (1.5 hours)	101	30%
91 minutes+	45	13%
30 minutes or less	27	8%

11. How many hours a week do you typically work?

Response	Count (n = 348)	Percent
32-40 hours	197	57%
Over 40 hours a week	59	17%
18-24 hours	31	9%
24-32 hours	29	8%
1-8 hours	19	5%
9-18 hours	13	4%

12. How do you feel about the numbers of hours that you currently work each week?

Response	Count (n = 348)	Percent
I am satisfied with the number of hours that I work.	275	79%
I would like to work more hours than I currently do.	46	13%
I would like to work less hours than I currently do.	27	8%

13. How long have you been working as a *[option selected in #1]* since entering this field, across all previous employers? If you are self-employed, how long have you been self-employed as a *[option selected in #1]*?

Response	Count (n = 324)	Percent
3-4 years	79	24%
1-2 years	74	23%
Less than one year	53	16%
More than 7 years	53	16%
5-6 years	52	16%
I volunteer	9	3%
Unemployed	4	1%

14. To what extent do you work in the following settings?

	Always	Frequently	Sometimes	Never	n
Community-based organization	147 (47%)	113 (36%)	37 (12%)	14 (5%)	311
Individual/family home	26 (9%)	109 (38%)	101 (35%)	49 (17%)	285
Clinic	24 (9%)	48 (18%)	97 (36%)	99 (37%)	268
Hospital	7 (3%)	19 (7%)	112 (41%)	132 (49%)	270
Government agency (e.g., county health department)	41 (15%)	53 (19%)	89 (32%)	97 (35%)	280
School	4 (2%)	25 (10%)	46 (18%)	187 (71%)	262
Forensic/legal	6 (2%)	23 (9%)	80 (31%)	152 (58%)	261

15. Have you experienced any difficulty finding work since becoming a *[option selected in #1]*?

Response	Count (n = 323)	Percent
No	255	79%
Yes	40	12%
Don't know/Unknown	28	9%

a. What has made it difficult to find work as a *[option selected in #1]*?

Theme	Count	Supporting Responses
Limited job opportunities available	30	▸ More applicants than positions ▸ Only knew of one organization that did the kind of work my certification allowed and there wasn't much turn over within the organization.

Inadequate hours and wages	9	▶ Salary is low for the work we do. ▶ Jobs pay very little.
Other	11	▶ Lack of car (3) ▶ Organizations do not understand the role of peers (2) ▶ Background checks (2) ▶ Inadequate work/education experience (2) ▶ Certification barriers (1) ▶ Challenges with people served (1)

16. Since you have joined the peer workforce, what is the total amount of time that you have been unemployed or unable to find peers/clients?

Response	Count (n = 309)	Percent
Less than 1 month	242	78%
1-6 months	36	12%
7-12 months	16	5%
More than 24 months	8	3%
13-18 months	6	2%
19-24 months	1	<1%

17. In the time you've been working for your current employer, or since you've been self-employed or volunteering, have your skills been appropriately utilized? "Appropriately utilized" means that you have done work that you are specifically trained to do within the scope of practice for your role as a peer.

Response	Count (n = 322)	Percent
Yes	291	90%
No	23	7%
Don't know/Unknown	8	2%

17a. Please list the kind of work you have done that falls outside of your skills or training as a *[option selected in Q1]*.

Theme	Count	Supporting Responses
Case management	5	▶ I have done case management in the past without training or pay increase. ▶ Case management most of the time
Clinical tasks (e.g., intakes, assessments, crisis phone)	8	▶ Doing clinical tasks that are outside of the Peer Support Model.

		▶ I also have been used to deescalate acute crisis situations when that is outside of my contract and my employer has not paid for me to take any de-escalation trainings.
Other	11	▶ Chores / errands (3) ▶ Forensic peer services (3) ▶ Teacher / trainer (2) ▶ Parental peer services (1) ▶ Interpreter (1) ▶ Administrative tasks (1)

18. Do you believe you have the sufficient skills and support to do your job?

Response	Count (n = 323)	Percent
Yes	287	89%
No	19	6%
Don't know/Unknown	17	5%

a. Please list some of the barriers to and/or challenges to obtaining the support and developing the skills necessary to do your job.

Theme	Count	Supporting Responses
Lack of training opportunities	11	▶ I would like more training. ▶ More harm reduction-based trainings should be available. There are many trainings for abstinence-based recovery model, but abstinence doesn't always fit into the peers idea of treatment for themselves.
Lack of supervision time	2	▶ I believe there is not enough time for supervisors to be sure that each person can be supported properly. There is not enough Supervision time or even access to a manager if need be. I wish there was mandatory, consultant support.
Other	6	▶ Limited housing resources for people services (2) ▶ Limited support / understanding of peer work (2) ▶ Lack of focus on self-care (1) ▶ Language / cultural barriers (1)

19. In your area, do you have adequate training opportunities or courses available to develop skills related to your job?

Response	Count (n = 318)	Percent
Yes	224	70%
No	63	20%
Don't know/Unknown	31	10%

a. Please list the types of training opportunities or courses that have most helped you develop skills related to your job.

Participants listed several specific training courses, such as:	
▶ Motivational Interviewing ▶ Crisis prevention ▶ Self-care ▶ Trauma-Informed Care ▶ Intergenerational trauma ▶ Healing trauma ▶ Mental Health First Aid (adult, youth, senior) ▶ Wraparound foundations training ▶ Suicide prevention (ASIST, QPR) ▶ Growing Through ▶ Diversity, Equity, Inclusion ▶ Wellness Recovery Action Plan ▶ Intentional Peer Support ▶ Assertive Engagement ▶ Boundaries	▶ Budgeting ▶ Communication skills ▶ Confidentiality ▶ Harm Reduction ▶ Transmittable disease testing ▶ Cultural bias/humility ▶ Compassion fatigue ▶ Microaggressions ▶ Culturally responsive trainings ▶ Ethics ▶ Emotional CPR ▶ Mental health and disabilities ▶ Money basics ▶ Forensics ▶ Naloxone ▶ Crucial Conversations
Participants listed several specific organizations or events from which they like receiving trainings, such as:	
▶ Peerpocalypse Conference ▶ Mental Health & Addiction Certification Board of Oregon (MHACBO) ▶ National Alliance on Mental Illness ▶ Daystar Education Inc. ▶ Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS)	▶ County trainings ▶ Peer retreats ▶ Oregon Health Authority ▶ Folk Time ▶ Mental Health & Addiction Association of Oregon (MHAAO) ▶ Hearing Voices Network ▶ MetroPlus Association of Addiction Peer Professionals (MAAPP)

b. Please list the types of training opportunities or courses that would best help you develop skills related to your job.

Participants listed several specific training courses, such as:	
▶ Working with non-peer colleagues ▶ Advocacy ▶ Parenting skills ▶ Technology skills ▶ Boundaries ▶ Medication Assisted Treatment ▶ Motivational Interviewing ▶ Counseling ▶ Communication skills ▶ Forensic peer support ▶ Hearing Voices Facilitation ▶ Support working with different populations of people (e.g., veterans, people experiencing homelessness, LGBTQ)	▶ Harm reduction ▶ Intentional Peer Support ▶ Mental Health First Aid ▶ Trauma-Informed Care ▶ Outreach support ▶ Ethics ▶ Peer scope ▶ Personality disorders ▶ Rapport building ▶ Time management ▶ Self-Empowerment ▶ WRAP ▶ Writing clinical notes ▶ Pregnant women and addiction
Participants listed several specific opportunities, such as:	
▶ Trainings in Spanish or other languages ▶ Affordable CEU courses	▶ More online trainings ▶ More trainings in rural areas

20. Who is responsible for paying for the continuing education units (CEUs) required to maintain your certification?

Response	Count (n = 323)	Percent
Organization/employer	225	70%
Self	98	30%
Scholarships	26	8%
Other - Write In ▶ Attend free trainings	5	2%

Note: Percentages do not equal 100 because "Other write-in" responses that fit into categories were recoded and several participants selected more than one category.

CURRENT WORKPLACE

21. Approximately how long have you been employed in your current peer job?

Response	Count (n = 310)	Percent
3-5 years	56	18%
Over 5 years	53	17%
7-12 months	44	14%

1-6 months	42	14%
13-18 months	42	14%
1 - 2 years	29	9%
2 - 3 years	28	9%
Not currently employed	16	5%

22. Where do you work? Please check the most accurate selection(s). You may select up to 3 options.

Response	Count (n = 295)	Percent
Within an organization: Non-Profit	235	80%
Community-based organization	67	23%
Peer-run organization	65	22%
In the Community	58	20%
Clinical Setting	41	14%
Drop-in Center	26	9%
State or county government agency	22	7%
In a Hospital or Institution	15	5%
Within an organization: For-Profit	13	4%
Independently I work for myself	11	4%
Forensic setting (e.g. jail, court, diversion program)	10	3%
School	3	1%
Self-employed	2	1%

23. What county or counties do you work in? Please check all that apply.

County	Count (n = 308)	Percent
Multnomah	122	40%
Washington	82	27%
Clackamas	73	24%
Marion	40	13%
Lane	37	12%
Yamhill	34	11%
Polk	22	7%
Benton	14	5%
Columbia	14	5%
Umatilla	14	5%
Jackson	12	4%
Josephine	12	4%
Linn	12	4%
Coos	11	4%
Lincoln	11	4%
Malheur	11	4%
Deschutes	10	3%

Union	10	3%
Wallowa	10	3%
Baker	9	3%
Klamath	9	3%
Wasco	9	3%
Curry	8	3%
Grant	8	3%
Morrow	8	3%
Clatsop	7	2%
Douglas	7	2%
Gilliam	7	2%
Harney	7	2%
Hood River	7	2%
Lake	7	2%
Sherman	7	2%
Wheeler	7	2%
Crook	6	2%
Tillamook	6	2%
Jefferson	5	2%

24. In your workplace, how many other peer workers are there (not including yourself)?

Response	Count (n = 308)	Percent
10+ other peer workers	73	24%
2-3 other peer workers	58	19%
4-5 other peer workers	39	13%
There is one other peer worker	39	13%
I'm the only peer in my work environment	37	12%
6-7 other peer workers	31	10%
8-10 other peer workers	31	10%

25. What is your favorite part of your job?

Theme	Count	Supporting Responses
Providing direct services to people	278	▸ **Making connections and building community** ○ I love working with my clients. They are wonderful people who are kind, caring, and very open-hearted. I notice that my mood improves while working with them. ○ Knowing I can connect with the peers I provide services to and that I can make a difference in their recovery. ▸ **Empowering people**

		○ I love empowering parents and watching them advocate for themselves and ask for help without "fear" of being judged. ○ Empowering people to be an active participant in their health care/ substance use treatment/ mental health where they can build sustainable change in their lives ▶ **Hearing and sharing personal stories** ○ Using my lived experience to make a difference in others' lives. ○ Supporting, encouraging and walking beside someone as they find their way, sharing from the perspective of my lived experience as appropriate. ▶ **Helping people reach their goals** ○ Not having an agenda....simply meeting someone where they are at and supporting them with their goals. ○ Meeting with clients and building a trusting relationship. Finding out what my client's goals are and helping them to figure out how to reach those goals. ▶ **Helping people learn new skills and get connected to resources** ○ Reintegrating clients from prison back into the community, using all the resources available, engaging with community partners, getting to know clients to a personal level and watch them grow in their recovery and getting their lives back together ○ Seeing the clients learn new life skills and graduate. I love seeing them gain the confidence to move forward. ▶ **Celebrating successes** ○ Watching clients accomplish their goals and watching them graduate IOP treatment ○ When I can see the residents thrive and be successful in what there working towards.
Coworkers/organizations	8	▶ The support from the organization ▶ My Team and the work we do together
Advocacy	7	▶ Changing hearts and minds of system administrators, clinicians, so things actually change for everyone using system moving forward and when individuals share appreciation for efforts, compassion, etc provided

		▶ Embracing the peer work of the organization and provide support and leadership as a board member
Other	6	▶ Community outreach (4) ▶ Developing Programs/trainings (2)

26. What is your least favorite part of your job?

Theme	Count	Supporting Responses
Administrative work, documentation, and other paperwork tasks	61	▶ Spending more time on our computers instead of our clients. ▶ Tracking paper work and notes if they are referred from mental health clinic
Difficult client situations – e.g., death, relapse, erratic behaviors	42	▶ Losing people to overdose or other drug/addiction/mental health related deaths. ▶ The client that become a statistic and die and the hopelessness
Limited access to resources to support people	28	▶ Feeling limited on what I can do to help my peers. We don't offer MH treatment, difficult time getting people housing, into TX, detox, no Insurance DR and dentist appointments glasses. ▶ Not being able to help individuals find adequate housing and or treatment when they are clean and sober
Difficult and oppressive organizations and systems	25	▶ System navigation and advocating in systems that don't consider the family voice or experience as valuable ▶ The broken, overworked, under-resourced systems I have to interact with to get access to services for the people I serve. All of the outrageous and ridiculous barriers they/we face accessing services. And the lack of services for what we really need: housing, substance use treatment on demand, and increased inpatient help for mental illness.
Lack of understanding and respect for the peer role	22	▶ Lack of understanding of role from some team members ▶ Microaggression from providers, having to constantly define my role to providers
Burnout and vicarious trauma	13	▶ Burnout/getting cynical or jaded to people's mistakes, behaviors. ▶ Crisis work can be tough and wear down on people including myself.

Other	72	▶ Low wages (14) ▶ Difficult or inconsistent hours and limited time (10) ▶ Terminating relationships (8) ▶ Misalignment of peer philosophy and medical / clinical model (7) ▶ Billing (5) ▶ Tasks outside scope (5) ▶ Lack of support from other peer workers (4) ▶ No career ladder (4) ▶ Driving (3) ▶ Lack of job security and limited funding for work (3) ▶ Lack of supervision (3) ▶ Non-peer coworkers (3) ▶ COVID-19 (2) ▶ Lack of training opportunities (1)

27. Are you interested in getting a new job/new employer?

Response	Count (n = 309)	Percent
No	174	56%
I'm thinking about it	83	27%
Yes	52	17%

a. Why are you interested in getting a new job?

Theme	Count
Better pay	11
Better benefits	10
Organizational culture	6
Improved commute	5
More opportunities for advancement elsewhere	9
Management / supervisors	8
Coworkers	4
Other ▶ Seeking different client interaction frequency or population (4)	12

▶ Seeking full time work (3) ▶ Seeking other job type or schooling (3) ▶ Prefer different hours (1) ▶ Lack of funding at current job (1)	

WORKPLACE ATTITUDES

28. Do you feel recognized and valued as a full member of your team?

Response	Count (n = 299)	Percent
Yes	210	70%
Sometimes	67	22%
No	22	7%

a. What would help you feel recognized and valued as a full member of your team?

Theme	Count	Supporting Responses
Coworkers understanding and respecting peer role	32	▶ At my organization, clinical staff don't fully understand what peers are for, nor are they required to know. It would benefit both the participants, as well as clinicians to care about knowing what other members of a team do. ▶ For my team to research the role/purpose of a peer support.
Work being acknowledged	14	▶ To be heard, acknowledged valued as someone who can offer valid perspective. ▶ Positive affirmations, recognition from other departments.
Better pay	11	▶ Better pay would be nice! The agency is quick to edify our valued experience vocally, but just not on a pay scale that one can support oneself. ▶ Pay Putting their money where their mouth is in terms of valuing self care and a trauma-informed work place.
Other	28	▶ More supportive and respectful organizational culture (6) ▶ More autonomy and voice in decision making (5) ▶ Better supervision (4) ▶ Doing work that matched the scope of peer work (3) ▶ Availability of consistent full-time work (3)

		▶ More opportunities for training and growth (3) ▶ Better Benefits (2) ▶ Better communication with coworkers (2)

29. Do you feel there is a career path available to you within your organization?

Response	Count (n = 297)	Percent
Yes	185	62%
No	112	38%

a. What career paths are available to you within your organization?

Theme	Count
Management, supervision, leadership	69
Counselor – e.g., CADC	28
Trainer	17
Different peer job	11
Case management	6
Continuing education	5
Create new career paths/expand current programming	4
Administrative positions	3
Advocacy / policy work	1

b. If no, why not?

Theme	Count
No jobs exist	68
Need additional degree / lack skills	9
Stigma / peer role not valued at organization	7
Lack of trust	4
Lack of funding	2
Unable to get other certification	2
Limitations due to background check	1

30. Do you feel valued in your position?

Response	Count (n = 297)	Percent
Yes	262	88%
No	35	12%

a. What makes you feel valued in your position?

Theme	Count
Receiving affirmation, acknowledgement, and support from coworkers and leadership	175
Encouraged to contribute	26
Increased responsibilities	15
Adequate pay/promotions	3

b. Can you tell us why you do not feel valued in your position?

Theme	Count
Not trusted or respected	14
Lack of understanding of peer role / asked to do work outside scope	6
Underpaid / overworked	4

SUPERVISION

31. How often do you receive supervision?

Response	Count (n = 293)	Percent
Once a week	91	31%
Twice a month	90	31%
Once a month	63	22%
More than once a week	22	8%
I do not receive supervision	16	5%
Less frequently than every two months	7	2%
Every two months	4	1%

a. Why don't you receive supervision?
b. How satisfied are you with the quality and frequency of the supervision you receive?

Response	Count (n = 276)	Percent
Highly satisfied	96	35%
Satisfied	92	33%
Somewhat satisfied	63	23%
Unsatisfied	19	7%
Highly unsatisfied	6	2%

32. What experience does your supervisor have?

Response	Count (n = 290)	Percent
Peer/lived experience	106	37%
Both	80	28%
Clinical experience	71	24%
Other - Write In	33	11%

33. How well does your direct supervisor understand the role, history, and scope of your worker type (PSS, PWS, CRM, FSS, etc.)?

Response	Count (n = 291)	Percent
Very well	149	51%
Well	56	19%
Somewhat well	46	16%
Not well at all	23	8%
I do not know/unsure	9	3%
Not at all	8	3%

MEDICAID AND PAYMENT MODELS

34. How interested are you in being able to bill insurance or Medicaid for your peer support services?

Response	Count (n = 276)	Percent
Very interested	118	43%
Somewhat interested	59	21%
I am not sure	51	18%
Not at all interested	48	17%

35. Do you find it intimidating to try to bill an insurance company or Medicaid for the peer support services you provide to their clients/members?

Response	Count (n = 265)	Percent
Not at all intimidating	128	48%

Somewhat intimidating	90	34%
Very intimidating	47	18%

36. For those who are an Oregon Health Authority-approved peer Traditional Health Worker on the registry, have you successfully billed (through your agency) and been reimbursed by Medicaid for your peer support services?

Response	Count (n = 265)	Percent
No	136	51%
Yes	90	34%
I am not on the state registry	39	15%

37. Would you be interested in the possibility of being eligible to become an OHA-approved THW Peer Support Specialist or Peer Wellness Specialist and to be directly reimbursed by Medicaid, if that becomes an option in the future?

Response	Count (n = 266)	Percent
Yes	169	64%
I'm not sure	75	28%
No	22	8%

38. What payment reimbursement model(s) do you see as being most beneficial for peer delivered services work?

Response	Count (n = 263)	Percent
Not sure/unknown	154	59%
Fee-for-service (FFS) (paid a fee for each service provided from an approved service list)	77	29%
Alternative payment model (APM) (payment other than FFS that is used to coordinate and integrate healthcare services. Provides added incentive payments to give high quality and cost-efficient care.)	64	24%
Values-based payment (VBP) (holds providers accountable for both the cost and the quality of care they deliver. Providers are rewarded financially for delivering better, more cost-effective care, and can be penalized for not meeting targets.)	44	17%

39. Which funding sources would you be most interested in pursuing should the option be made available? Please rank the below options from 1 – 5, with 1 being "most interested" and 5 being "least interested".

	1	2	3	4	5	n
Contract with coordinated care organizations (CCOs)	62 (32%)	41 (21%)	28 (15%)	27 (14%)	33 (17%)	191

Contract or receive grants from state or county	68 (34%)	48 (24%)	25 (12%)	33 (16%)	26 (13%)	200
Directly bill Medicaid as an individual peer provider	30 (17%)	35 (20%)	42 (24%)	43 (25%)	24 (14%)	174
Bill Medicaid through a peer-run organization	30 (16%)	34 (19%)	63 (35%)	32 (18%)	23 (13%)	182
Directly bill private/commercial insurance	31 (16%)	24 (13%)	30 (16%)	42 (22%)	64 (34%)	191

PAY AND BENEFITS

40. What are your wages?

Metric	Value
Minimum	$0
Maximum	$50
Mean	$18.26
Median	$17.50

41. What is your total annual income as a result of your work as a [option selected in Q1]?

Response	Count (n = 255)	Percent
$30,001 to $40,000	96	38%
$20,001 to $30,000	60	24%
$40,001 to $50,000	37	15%
$10,001 to $20,000	34	13%
$10,000 or less	18	7%
$50,001 or more	10	4%

42. How satisfied are you with your pay?

Response	Count (n = 260)	Percent
Somewhat satisfied	104	40%
Not satisfied	71	27%
Satisfied	63	24%
Very Satisfied	22	8%

43. Do you receive benefits? Check all that apply.

Response	Count (n = 253)	Percent
Vacation time	206	81%

Medical	190	75%
Dental	177	70%
Vision	161	64%
Retirement: 401k, 403b, etc.	129	51%
I do not receive benefits.	43	17%

44. How satisfied are you with your benefits?

Response	Count (n = 259)	Percent
Satisfied	94	36%
Somewhat satisfied	61	24%
Very Satisfied	61	24%
Not satisfied	43	17%

45. Do you get paid time off? Check all that apply.

Response	Count (n = 262)	Percent
Vacation time	222	85%
Sick time	209	80%
Holidays	198	76%
Wellness days	80	31%
Unpaid time off	61	23%
Paid volunteer days	41	16%
I do not receive time off benefits.	24	9%

<u>CULTURALLY AND LINGUISTICALLY-SPECIFIC SERVICES</u>

46. Are you able to provide culturally- and linguistically-specific peer support services?

Response	Count (n = 265)	Percent
Yes	148	56%
No	71	27%
Don't Know/Unknown	46	17%

a. Do you have the ability to connect with someone within your organization who can provide culturally-and linguistically-specific peer support services?

Response	Count (n = 117)	Percent
Yes	62	53%
No	30	26%
Don't know/Unknown	25	21%

47. Please list some of the barriers, challenges, and/or successes you have experienced in providing culturally- and linguistically-specific peer support services.

Theme	Count
Access to high quality interpreters – e.g., Spanish, American Sign Language	24
Language barriers	15
Lack of diversity in the peer workforce	14
Varying needs of people served	13
Lack of adequate training	11
Organizational leadership does not value and funding	3
Stigma / discrimination	3

48. Do the employees in your workplace reflect the diversity of the communities you serve?

Response	Count (n = 262)	Percent
Yes	176	67%
No	60	23%
Don't know/Unknown	26	10%

a. What could be done to promote equity and inclusion and improve the diversity of your workplace?

Theme	Count
More diversity in the workforce	66
More trainings	50
More services available for people being served	7
More opportunities and pay to retain current staff	2
More peer-led organizations	1

Please share any other thoughts, comments, or recommendations that you have regarding the peer workforce in Oregon.

<u>REAL+D Questions from the Oregon Health Authority</u>

49. In your own words, how would you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?

50. Which of the following describes your racial or ethnic identity? *Please check ALL that apply.*

Response	Count (n = 501)	Percent
Western European	108	22%
Other White	56	11%
Eastern European	40	8%
American Indian	25	5%
Hispanic or Latino Mexican	17	3%
African American	12	2%
Other (please list)	12	2%
Don't want to answer/Decline	11	2%
Slavic	9	2%
Other Hispanic or Latino	6	1%
Don't know/Unknown	6	1%
Middle Eastern	4	1%
Indigenous Mexican, Central American or South American	3	1%
Hispanic or Latino Central American	3	1%
Other Black	3	1%
Hispanic or Latino South American	2	<1%
Other Pacific Islander	2	<1%
African (Black)	2	<1%
Alaska Native	1	<1%
Asian Indian	1	<1%
Filipino/a	1	<1%
Vietnamese	1	<1%
Other Asian	1	<1%
Native Hawaiian	1	<1%

51. Please select one racial or ethnic identity that best represents your primary racial or ethnic identity.

52. What language do you typically prefer to use outside of the home when speaking about important matters?

Response	Count (n = 249)	Percent
English	242	97%
Spanish	5	2%
Don't Want to Answer/Decline	2	1%

53. What language do you typically prefer to use outside of the home when receiving important written communications?

Response	Count (n = 242)	Percent
English	239	99%
Spanish	3	1%

54. Do you need a sign language interpreter for us to communicate with you?

Response	Count (n = 244)	Percent
No	242	99%
Yes	2	1%

a. Which type do you need us to communicate with you?

Response	Count (n = 2)	Percent
ASL - American Sign Language	1	50%
Don't Want to Answer/Decline	1	50%

55. When communicating in person with others (such as the doctor's office) do you need a spoken language interpreter?

Response	Count (n = 244)	Percent
No	240	98%
Yes	2	1%
Don't Know/Unknown	1	<1%
Don't Want to Answer/Decline	1	<1%

56. How well do you speak English?

Response	Count (n = 249)	Percent
Very Well	230	92%
Well	16	6%
Not Well	2	1%
Don't Want to Answer/Decline	1	<1%

57. Are you deaf or do you have serious difficulty hearing?

Response	Count (n = 248)	Percent
No	233	94%
Yes	12	5%

Don't Want to Answer/Decline	2	1%
Don't Know/Unknown	1	<1%

a. At what age did this condition begin?

58. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

Response	Count (n = 246)	Percent
No	238	97%
Don't Want to Answer/Decline	3	1%
Yes	3	1%
Don't Know/Unknown	2	1%

a. At what age did this condition begin?

59. Do you have serious difficulty walking or climbing stairs?

Response	Count (n = 244)	Percent
No	217	89%
Yes	20	8%
Don't Want to Answer/Decline	7	3%

a. At what age did this condition begin?

60. Do you have difficulty dressing or bathing?

Response	Count (n = 249)	Percent
No	244	98%
Don't Want to Answer/Decline	3	1%
Yes	2	1%

a. At what age did this condition begin?

61. Because of a physical, mental, or emotional condition, do you have serious difficulty:

	Yes	No	Don't Know/ Unknown	Don't Want to Answer/Decline	n
a. Concentrating, remembering, understanding, or making decisions?	40	179	8	17	244

b. Doing errands alone such as visiting a doctor's office or shopping?	10	217	5	10	242

61c. At what age did you begin to have serious difficulty concentrating, remembering, understanding, or making decisions?

61d. At what age did you begin to have serious difficulty doing errands alone such as visiting a doctor's office or shopping?

62. Does a physical, mental, or emotional condition limit your activities in any way?

Response	Count (n = 246)	Percent
No	139	57%
Yes	84	34%
Don't Want to Answer/Decline	18	7%
Don't Know/Unknown	5	2%

63. What is your age today?

Metric	Value
Minimum	22
Maximum	83
Mean	47
Median	46

64. What are your preferred pronouns?

Response	Count (n = 246)	Percent
She/Her/Hers	153	62%
He/Him/His	69	28%
Don't Want to Answer/Decline	12	5%
Additional pronouns not listed (please specify):	6	2%
Don't Know/Unknown	4	2%
They/Them/Their	2	1%

65. What sex were you assigned at birth on your original birth certificate?

Response	Count (n = 245)	Percent
Female	163	67%
Male	76	31%
Don't Want to Answer/Decline	6	2%

66. What is your current gender identity? *Select ALL that apply*

Response	Count (n = 256)	Percent
Female	159	62%
Male	74	29%
Gender Fluid	6	2%
Non-Binary	6	2%
Gender Nonconforming	3	1%
Transgender male	2	<1%
Genderqueer	2	<1%
Gender Expansive	2	<1%
Transgender female	1	<1%
Questioning	1	<1%

67. Which of the following best represents how you think of yourself?

Response	Count (n = 244)	Percent
Straight/Heterosexual	176	72%
Bisexual	16	7%
Additional Category (please specify):	13	5%
Don't Want to Answer/Decline	13	5%
Lesbian	12	5%
Queer	7	3%
Gay	5	2%
Don't Know/Unknown	1	<1%
Questioning	1	<1%

68. Please provide any additional comments about your experience as a *[option selected in Q1]* below.

Appendix I: Employer Survey

BASIC ORGANIZATIONAL INFORMATION

1. How would you classify your organization? Please check all that apply.

Response	Count (n = 102)	Percent
Non-profit	34	33%
Peer-run organization	19	19%
Community-based organization	18	18%
Mental health or addiction provider	16	16%
Social-service organization	12	12%
Government agency	10	10%
Coordinated care organization	5	5%
Hospital or clinic	1	1%
Forensic/corrections	1	1%

2. Please approximate the following numbers for your organization:

Metric	TOTAL EMPLOYEES	TOTAL CONTRACTORS	TOTAL VOLUNTEERS
Mean	266	38	34
Median	52	8	10
Minimum	2	0	0
Maximum	2300	400	200

3. What is your organization's approximate annual operating budget?

Response	Count (n = 48)	Percent
Unknown	11	23%
Between $1,000,000 - $4,000,000	9	19%
Over $125,000,000	8	17%
Under $500,000	8	17%
Between $500,000 - $999,999	5	10%
Between $10,000,000 - $25,000,000	3	6%
Between $75,000,001 - $125,000,000	2	4%
Between $4,000,001 $9,999,999	1	2%
Prefer not to answer	1	2%

4. In which counties does your organization provide services? Please check all that apply.

Response	Count (n = 45)	Percent
Multnomah	24	53%
Clackamas	21	47%
Washington	18	40%
Marion	13	29%

Lane	9	20%
Yamhill	9	20%
Benton	6	13%
Lincoln	6	13%
Linn	6	13%
Polk	6	13%
Wasco	6	13%
Columbia	5	11%
Coos	5	11%
Jackson	5	11%
Baker	4	9%
Clatsop	4	9%
Deschutes	4	9%
Douglas	4	9%
Gilliam	4	9%
Grant	4	9%
Harney	4	9%
Hood River	4	9%
Josephine	4	9%
Klamath	4	9%
Lake	4	9%
Malheur	4	9%
Morrow	4	9%
Sherman	4	9%
Tillamook	4	9%
Umatilla	4	9%
Union	4	9%
Wallowa	4	9%
Wheeler	4	9%
Crook	3	7%
Curry	3	7%
Jefferson	3	7%

5. How familiar is your organization with the field of peer delivered services?

Response	Count (n = 49)	Percent
Extremely	37	76%
Moderately	8	16%
Slightly	2	4%
Somewhat	2	4%

6. Does your organization employ peer workers?

Response	Count (n = 49)	Percent

Yes	43	88%
No	5	10%
I am not sure.	1	2%

PEER DELIVERED SERVICES WITHIN YOUR WORKPLACE

7. Which type(s) of peer workers does your organization employ?

Response	Count (n = 39)	Percent
Peer Support Specialist - Mental Health	30	77%
Peer Support Specialist - Addictions	20	51%
Certified Recovery Mentor - Addictions (certified through MHACBO)	20	51%
Subtype not known	20	51%
Peer Wellness Specialist - Mental Health	14	36%
Peer Support Specialist - Youth Support Specialist	7	18%
Peer Wellness Specialist - Addictions	7	18%
Peer Support Specialist - Family Support Specialist	6	15%
Certified Gambling Recovery Mentor - Addictions (certified through MHACBO)	6	15%
Peer Wellness Specialist - Family Support Specialist	2	5%

a. How many persons are employed or contracted with in this position with your organization?
b. What is the total full-time equivalency (FTE) for this peer worker type?
c. What is the pay range for this position?

Metric	Persons employed	Total FTE	Pay range
Minimum	0	1	$11.56
Maximum	100	75	$31.00
Mean	21	16	$18.69
Median	6	5	$17.00

8. Are you currently contracting with community-based organizations to provide peer delivered services?

Response	Count (n = 41)	Percent
We are a community-based organization that provides peer services.	17	41%
Yes, we contract with multiple community-based organizations to provide peer support to those we serve.	14	34%
No	6	15%
Yes, we contract with one community-based organization to provide peer support services.	4	10%

9. Would you like to be able to offer peer delivered services to your members/clients/consumers?

Response	Count (n = 33)	Percent
We already offer peer delivered services.	19	58%
Yes	13	39%
I am not sure/undecided	1	3%

a. If you aren't currently offering peer delivered services, what barriers are you experiencing to implementation?
b. What would your organization need in order to be interested in offering peer delivered service?

10. Has your organization experienced any challenges in hiring and retaining qualified peer delivered service providers?

Response	Count (n = 40)	Percent
Yes	22	55%
No	9	22%
Not sure	9	22%

a. Please share what challenges you have experienced related to hiring and retaining qualified peer workers.

Theme	Count
Finding qualified candidates	10
Ability to provide appropriate supervision	3
Ability to provide competitive wages/benefits	3
Peer workers maintaining recovery and appropriate boundaries with people being served	3
Ability to maintain consistent funding and people to serve	2
Finding candidates with diverse background	2
Length of background check process	1

11. How frequently do peer delivered services staff receive supervision?

Response	Count (n = 39)	Percent
Once a week	15	38%
Twice a month	10	26%
I am not sure.	5	13%
More than once a week	5	13%
Once a month	4	10%

12. How are supervisors of peer workers supported to understand the role, scope, and values of peer support positions? Please check all that apply.

Response	Count (n = 38)	Percent
Supervisors have access to as-needed supervision and technical assistance	23	61%
Supervisors receive relevant training prior to working with peer staff	22	58%
Supervisors of peer workers have experience working within peer roles themselves	20	53%
Supervisors are provided materials on peer delivered services in Oregon to review	19	50%
I am not sure	9	24%
Supervisors are not provided any additional or special support	2	5%

13. How are your organization's peer positions funded?

Response	Count (n = 39)	Percent
County grants or contracts	20	51%
State grants or contracts	11	28%
Medicaid-billable position	7	18%
Federal grant	7	18%
General fund	5	13%
Positions are volunteer	3	8%
Fundraising/endowments	2	5%

Note: Percentages do not equal 100 because "Other write-in" responses that fit into categories were recoded and several participants selected more than one category.

PAYMENT MODELS AND REIMBURSEMENT PATHWAYS

14. How interested is your organization in being able to bill insurance or Medicaid for peer support services?

Response	Count (n = 36)	Percent
Very interested	16	44%
I am not sure	9	25%
Not at all interested	7	19%
Somewhat interested	4	11%

15. For those who employ Oregon Health Authority-approved peer Traditional Health Workers, has your agency successfully billed and been reimbursed by Medicaid for peer support services?

Response	Count (n = 33)	Percent
No	15	45%
I am not sure.	12	36%
Yes	6	18%

a. Please briefly tell us about your experience, including successes, any barriers, and challenges your organization has experienced related to Medicaid or other payment reimbursement for peer delivered services.

Theme	Count	Supporting Responses
Reimbursement rates do not cover cost of services	3	▸ Billing is fairly simple. Reimbursement rates do not cover cost of peers. In rural/frontier areas, the travel time is so extremely extensive and is not reimbursable. It is not sustainable. ▸ concern about covering all costs of peers when not all time may be medicaid reimbursed ▸ Medicaid alone also will not sustain these positions. More codes and modifiers need to be created for better sustainability.
Other	7	▸ Do not have problems with payment reimbursement (2) ▸ Do not bill for services (2) ▸ Challenges renewing contracts (1) ▸ CCOs unfamiliar with billing non-medical services (1) ▸ Billing process leads to role confusion (1) ○ This process can create scope creep for the peer and create some role confusion later on.

16. Which payment reimbursement model(s) do you see as being most beneficial for peer delivered services work?

Response	Count (n = 37)	Percent
Not sure/unknown	13	35%
Fee-for-service (FFS)	12	32%
Alternative payment model (APM)	11	30%

Values-based payment (VBP)	9	24%
Other - Write In ▶ We have been open to different kinds of contractual relationships. ▶ We wish to keep ours a no fee organization.	3	8%

a. Please share any other thoughts or comments that you have about payment reimbursement models for peer delivered services.

Theme	Count	Supporting Responses
Payment reimbursement that funds a peer position instead of services better aligns with client-center approach	4	▶ Contract to pay for the position rather than the service ▶ To provide true peer delivered services, peers should not have to be constrained by Medicaid regulations, which tie peers into providing a set list of services and not being able to provide what the consumer needs. ▶ VBP and payment for FTE has been the most effective payment model we have found for reaching the most people wanting peer support. This model allows the flexibility needed for peers to provide the support to fidelity. ▶ We need to be careful that we do not drive small organizations doing amazing work with having to bill and all the problems that are associated with that model of providing support.
Contracts are often unclear and have complex reporting requirements	2	▶ I think we have received FFS types of payments, where there was not a clear agreement about what constitutes quality and cost-effectiveness. ▶ The extremely extensive level of data collecting and data reporting we are expected to do in order to receive our funding is a barrier to offering our services. We are at risk of presenting ourselves in a manner that is more aligned with clinicians. Our support should reach beyond families' PHI/demographics so that we continue to stand out as walking along side of our families and offering true peer support. the reporting requirements are becoming more and more intensive, causing undue stress on our peer specialists and our supervisors.

Medicaid billing needs separate reimbursement code for peer services	2	▶ Having a separate reimbursement for peer support would be helpful to recognize the uniqueness of the role. ▶ There is currently no mechanism in place to allow providers to generate revenue for Peers doing outreach and engagement activities. This is VERY important work and needs to be reimbursable!
No model is perfect	1	▶ These models have pros and cons and we are still trying to find or create a model that truly values the work that we do.

17. Which funding sources would you be most interested in pursuing should the option be made available? Please rank the below options from 1 – 5, with 1 being "most interested" and 5 being "least interested".

	1	2	3	4	5	6
Contract with coordinated care organizations (CCOs)	17 (49%)	9 (26%)	4 (11%)	5 (14%)	0	0
Contract or receive grants from state or county	18 (53%)	8 (24%)	5 (15%)	1 (3%)	2 (6%)	0
Contract with peer providers who directly bill Medicaid themselves	3 (9%)	4 (12%)	9 (28%)	5 (16%)	5 (16%)	6 (19%)
Bill Medicaid	6 (19%)	4 (13%)	10 (32%)	3 (10%)	5 (16%)	3 (10%)
Directly bill private/commercial insurance	5 (16%)	4 (13%)	13 (42%)	0	5 (19%)	3 (10%)

CULTURALLY AND LINGUISTICALLY-SPECIFIC SERVICES

18. Is your organization able to provide culturally- and linguistically-specific peer support services?

Response	Count (n = 36)	Percent
Yes	25	69%
Don't Know/Unknown	6	17%
No	5	14%

a. Do you have the ability to connect with someone outside of your organization who can provide culturally-and linguistically-specific peer support services?

Response	Count (n = 11)	Percent
Don't know/Unknown	5	45%
Yes	5	45%

No	1	9%

19. Please list some of the barriers, challenges, and/or successes your agency has experienced in providing culturally- and linguistically-specific peer support services.

20. Do the employees in your workplace reflect the diversity of the communities you serve?

Response	Count (n = 36)	Percent
Yes	26	72%
No	7	19%
Don't know/Unknown	3	8%

a. What could be done to promote equity and inclusion and improve the diversity of your workplace?

Theme	Count	Supporting Responses
Implement better recruitment strategies	4	▶ better recruitment Marion Co is not diverse per see ▶ Help us to connect with a more diverse pool of peer support specialists for hiring. ▶ Intentional recruitment and building relationships with diverse communities ▶ Simplify the application process
Ability to offer more stable employment	1	▶ It would be nice to be able to afford and attract skilled PSSs to work with the diverse cultures at our organization. The PSSs we hire are usually part time and there is instability in our financial outlook with contracts ending and beginning again.
Better understanding of diversity within communities and available resources for diverse communities	1	▶ A better understanding of the diversity of the communities in our county and a better understanding of the resources available.
Increase diversity of peer workforce overall	1	▶ We have lots of internship opportunities; would love to increase diversity generally of individuals entering field and could provide multiple professional development opportunities.

<u>BARRIERS, SUCCESSES, AND TECHNICAL ASSISTANCE</u>

21. If you do not currently offer peer delivered services within your workplace, what would you want or need to consider its implementation?

Responses
▸ Funding and other capacity, including HIPAA. ▸ I believe Home Forward should begin by contracting peer services and eventually hire their own peers. I am genuinely surprised this is not already happening. ▸ Our county leadership would have to approve of this job category.

22. Please share any barriers to supporting peer traditional health worker positions within your workplace.

Theme	Count	Supporting Responses
Understanding the role of peers	3	▸ Supervisors and co-workers who have an, "Us-Therapists, etc., and Them, Peer Support/Wellness workers," conceptual understanding, seeing Peer Services as the "lesser value services" we represent to the individuals we serve. ▸ Travel time. Small populations. Value of peers is just beginning to be noticed.
Building sustainable infrastructure for workforce	2	▸ Building a sustainable infrastructure for ongoing support and reimbursement. ▸ need better policies and benefits that address barrier and more inclusive to support peer health workers
Other	7	▸ Funding (2) ▸ Ability to provide adequate supervision (2) ▸ Background checks (1) ▸ Need more local trainings (1) ▸ Retention (1) ○ Retaining staff with lived mental health experience can be a challenge. We offer hours to suit the employee and a pure peer environment, but often the individual is not ready and able to maintain employment.

23. Please share any successes or benefits experienced as a result of having peer positions within your workplace.

Theme	Count	Supporting Responses

Shared experience provides hope for people	7	▶ having peer walk along side on our members has been very beneficial. We hope to continue this movement. ▶ Our families have the opportunity to work with a support person who identifies therefore services can be received with less fear of judgment and shame. ▶ Peers are able to build relationships with clients that are unique to their role and tremendously helpful in healing and wellness.
Increased client engagement	3	▶ Definitely a huge boon to engagement and service relevance. ▶ increased persistence of families, empowerment and protective factors increasing ▶ Peers have really helped families and their children. Peers have been extremely beneficial in getting families to engage and become successful in services.
Better client outcomes	2	▶ Reduced crime rate in community lower instance in overdose related deaths we get to employ the so called unemployable to give voice to those who don't know they have a voice
Other	2	▶ Additional support to navigate systems (1) ▶ Increased collaboration with other organizations (1)

24. Are you interested in learning more about peer delivered services?

Response	Count (n = 35)	Percent
Yes	21	60%
No	10	29%
Not sure	4	11%

a. Which of the following options would you be most interested in receiving? Please check all that apply.

Response	Count (n = 22)	Percent
Visit to a site providing peer delivered services	14	64%
Two-hour onsite training	13	59%
One-hour webinar	12	55%
One-page informational sheet on peer delivered services	11	50%
Presentation by consumers/members receiving peer delivered services	11	50%

25. Would you like to be added to the Oregon Peer Delivered Services Coalition mailing list to receive emails (typically monthly) with resources, events, and training opportunities relevant to the peer workforce?

Response	Count (n = 34)	Percent
Yes	25	74%
No	9	26%

Appendix J: Statewide peer-delivered service workforce counts with primary ethnic identification

This data was derived from information on the public THW registry provided by OHA's OEI.

TRADITIONAL HEALTH WORKER PEER REGISTRY REPRESENTATION, 2020										
PRIMARY ETHNICITY	PSS- Adult MH	PSS- Adult Addictions	PSS - Family Support	PSS - Youth Support	PWS - Adult MH	PWS - Adult Addictions	PWS - Family Support	PWS - Youth Support	TOTALS	PERCENTAGE OF WORKFORCE
African (Black)	2	2	0	0	0	0	0	0	4	0.14
African American	6	26	0	2	2	0	0	0	36	1.27
American Indian	6	25	5	4	8	1	0	0	49	1.73
Caribbean (Black)	0	0	0	0	1	0	0	0	1	0.04
Decline/don't want to answer	29	18	5	5	5	0	0	0	62	2.19
Don't know/unknown	4	3	3	3	1	0	1	1	16	0.56
Eastern European	7	18	0	0	0	0	0	0	25	0.88
Filipino/a	0	0	1	0	0	0	0	0	1	0.04
Hispanic or Latino Central American	1	1	0	0	0	0	0	0	2	0.07
Hispanic or Latino Mexican	3	4	1	1	1		0	0	10	0.35
Indigenous Mexican, Central American or South American	0	0	0	1	2	1	0	0	4	0.14
Japanese	1	0	0	0	1	0	0	0	2	0.07
Micronesian	0	0	0	1	0	0	0	0	1	0.04
Middle Eastern	1	0	0	1	0	0	0	0	2	0.07
Native Hawaiian	1	2	0	0	0	0	0	0	3	0.11
Other	6	19	2	1	0	0	0	0	28	0.99
Other Asian	1	1	0	1	0	0	0	0	3	0.11
Other Black	1	0	0	1	0	0	0	0	2	0.07
Other Hispanic or Latino	2	5	0	0	1	0	0	0	8	0.28
Other Pacific Islander	1	0	0	0	1	0	0	0	2	0.07
Other White	71	124	17	8	9	1	1	0	231	8.15
Slavic	1	0	0	1	0	0	0	0	2	0.07
Western European	34	34	6	2	6	3	0	0	85	3
(blank - response not provided)	556	1271	135	70	151	69	2	1	2255	79.57

Appendix K: Peer-delivered services certification counts

Peer-delivered services providers on the Traditional Health Worker Registry by county, current as of September 2020

Please note that the data only indicates the numbers of THW registry applicants who selected which county(ies) they are available to work in - some applicants have selected multiple counties, and some have selected counties beyond their area of the state. OHA has shared that >1 have listed all 36 Oregon counties on their application. The below data is from the publicly available THW registry from a document provided by OEI, and in alphabetical order by county name.

ACTIVE PEER TRADITIONAL HEALTH WORKERS ON THE OHA REGISTRY	
CERTIFICATION TYPE	**COUNT**
PSS - Adult Addictions	1552
PSS - Adult Mental Health	735
PSS - Family Support	175
PSS - Youth Support	102
PWS - Adult Addictions	75
PWS - Adult Mental Health	189
PWS - Family Support	4
PWS - Youth Support	2
TOTAL CERTIFIED	**2834**

PEER WORKER TYPES BY COUNTY	
BAKER	**WORKER TYPE**
45	PSS - Adult Addictions
23	PSS - Adult Addictions & Mental Health
63	PSS - Adult Mental Health
21	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
BENTON	**WORKER TYPE**
60	PSS - Adult Addictions
31	PSS - Adult Addictions & Mental Health
87	PSS - Adult Mental Health
27	PSS - Family Support
10	PSS - Youth Support
4	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
19	PWS - Adult Mental Health
1	PWS - Youth Support
1	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
CLACKAMAS	**WORKER TYPE**
183	PSS - Adult Addictions
54	PSS - Adult Addictions & Mental Health
212	PSS - Adult Mental Health
47	PSS - Family Support
35	PSS - Youth Support
15	PWS - Adult Addictions
34	PWS - Adult Addictions & Mental Health
86	PWS - Adult Mental Health
1	PWS - Youth Support
3	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
CLATSOP	**WORKER TYPE**
47	PSS - Adult Addictions
25	PSS - Adult Addictions & Mental Health
72	PSS - Adult Mental Health
19	PSS - Family Support
8	PSS - Youth Support
4	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
21	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
COLUMBIA	**WORKER TYPE**
56	PSS - Adult Addictions
28	PSS - Adult Addictions & Mental Health
80	PSS - Adult Mental Health
20	PSS - Family Support
11	PSS - Youth Support
4	PWS - Adult Addictions
7	PWS - Adult Addictions & Mental Health
20	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
COOS	**WORKER TYPE**
55	PSS - Adult Addictions
26	PSS - Adult Addictions & Mental Health
76	PSS - Adult Mental Health
24	PSS - Family Support
16	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
20	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
CROOK	**WORKER TYPE**
45	PSS - Adult Addictions
26	PSS - Adult Addictions & Mental Health
69	PSS - Adult Mental Health
21	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
CURRY	**WORKER TYPE**
45	PSS - Adult Addictions
23	PSS - Adult Addictions & Mental Health
69	PSS - Adult Mental Health
22	PSS - Family Support
10	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
DESCHUTES	**WORKER TYPE**
53	PSS - Adult Addictions
30	PSS - Adult Addictions & Mental Health
85	PSS - Adult Mental Health
26	PSS - Family Support
9	PSS - Youth Support
4	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
DOUGLAS	**WORKER TYPE**
61	PSS - Adult Addictions
28	PSS - Adult Addictions & Mental Health
68	PSS - Adult Mental Health
24	PSS - Family Support
11	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
20	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
GILLIAM	**WORKER TYPE**
42	PSS - Adult Addictions
24	PSS - Adult Addictions & Mental Health
64	PSS - Adult Mental Health
17	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
GRANT	**WORKER TYPE**
46	PSS - Adult Addictions
25	PSS - Adult Addictions & Mental Health
65	PSS - Adult Mental Health
18	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
HARNEY	**WORKER TYPE**
43	PSS - Adult Addictions
24	PSS - Adult Addictions & Mental Health
62	PSS - Adult Mental Health
19	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
HOOD RIVER	**WORKER TYPE**
47	PSS - Adult Addictions
26	PSS - Adult Addictions & Mental Health
73	PSS - Adult Mental Health
22	PSS - Family Support
11	PSS - Youth Support
4	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
20	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
JACKSON	**WORKER TYPE**
129	PSS - Adult Addictions
28	PSS - Adult Addictions & Mental Health
99	PSS - Adult Mental Health
29	PSS - Family Support
18	PSS - Youth Support
3	PWS - Adult Addictions
6	PWS - Adult Addictions & Mental Health
19	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
JEFFERSON	**WORKER TYPE**
48	PSS - Adult Addictions
26	PSS - Adult Addictions & Mental Health
71	PSS - Adult Mental Health
21	PSS - Family Support
9	PSS - Youth Support
4	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
JOSEPHINE	**WORKER TYPE**
82	PSS - Adult Addictions
27	PSS - Adult Addictions & Mental Health
92	PSS - Adult Mental Health
27	PSS - Family Support
17	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
KLAMATH	**WORKER TYPE**
53	PSS - Adult Addictions
28	PSS - Adult Addictions & Mental Health
77	PSS - Adult Mental Health
22	PSS - Family Support
15	PSS - Youth Support
4	PWS - Adult Addictions
7	PWS - Adult Addictions & Mental Health
19	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
LAKE	**WORKER TYPE**
44	PSS - Adult Addictions
24	PSS - Adult Addictions & Mental Health
63	PSS - Adult Mental Health
21	PSS - Family Support
9	PSS - Youth Support
3	PWS - Adult Addictions
5	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY

LANE	WORKER TYPE
100	PSS - Adult Addictions
52	PSS - Adult Addictions & Mental Health
154	PSS - Adult Mental Health
40	PSS - Family Support
20	PSS - Youth Support
4	PWS - Adult Addictions
6	PWS - Adult Addictions & Mental Health
21	PWS - Adult Mental Health
1	PWS - Youth Support
1	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
LINCOLN	WORKER TYPE
57	PSS - Adult Addictions
28	PSS - Adult Addictions & Mental Health
73	PSS - Adult Mental Health
29	PSS - Family Support
9	PSS - Youth Support
4	PWS - Adult Addictions
5	PWS - Adult Addictions & Mental Health
20	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
LINN	WORKER TYPE
75	PSS - Adult Addictions
33	PSS - Adult Addictions & Mental Health
97	PSS - Adult Mental Health
31	PSS - Family Support
12	PSS - Youth Support
3	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
20	PWS - Adult Mental Health
1	PWS - Youth Support
1	PWS - Family Support

PEER WORKER TYPES BY COUNTY

MALHEUR	WORKER TYPE
46	PSS - Adult Addictions
23	PSS - Adult Addictions & Mental Health
62	PSS - Adult Mental Health
21	PSS - Family Support
9	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
MARION	**WORKER TYPE**
96	PSS - Adult Addictions
35	PSS - Adult Addictions & Mental Health
156	PSS - Adult Mental Health
42	PSS - Family Support
23	PSS - Youth Support
7	PWS - Adult Addictions
5	PWS - Adult Addictions & Mental Health
26	PWS - Adult Mental Health
1	PWS - Youth Support
1	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
MORROW	**WORKER TYPE**
42	PSS - Adult Addictions
24	PSS - Adult Addictions & Mental Health
64	PSS - Adult Mental Health
21	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY

MULTNOMAH	WORKER TYPE
265	PSS - Adult Addictions
63	PSS - Adult Addictions & Mental Health
266	PSS - Adult Mental Health
46	PSS - Family Support
37	PSS - Youth Support
18	PWS - Adult Addictions
38	PWS - Adult Addictions & Mental Health
104	PWS - Adult Mental Health
1	PWS - Youth Support
3	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
POLK	WORKER TYPE
64	PSS - Adult Addictions
31	PSS - Adult Addictions & Mental Health
124	PSS - Adult Mental Health
32	PSS - Family Support
15	PSS - Youth Support
4	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
23	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
SHERMAN	WORKER TYPE
44	PSS - Adult Addictions
23	PSS - Adult Addictions & Mental Health
64	PSS - Adult Mental Health
18	PSS - Family Support
9	PSS - Youth Support
3	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY

TILLAMOOK	WORKER TYPE
54	PSS - Adult Addictions
26	PSS - Adult Addictions & Mental Health
69	PSS - Adult Mental Health
23	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
7	PWS - Adult Addictions & Mental Health
24	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
UMATILLA	WORKER TYPE
49	PSS - Adult Addictions
26	PSS - Adult Addictions & Mental Health
66	PSS - Adult Mental Health
32	PSS - Family Support
11	PSS - Youth Support
4	PWS - Adult Addictions
3	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
UNION	WORKER TYPE
48	PSS - Adult Addictions
24	PSS - Adult Addictions & Mental Health
64	PSS - Adult Mental Health
22	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY

WALLOWA	WORKER TYPE
41	PSS - Adult Addictions
25	PSS - Adult Addictions & Mental Health
64	PSS - Adult Mental Health
20	PSS - Family Support
8	PSS - Youth Support
4	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
WASCO	**WORKER TYPE**
42	PSS - Adult Addictions
25	PSS - Adult Addictions & Mental Health
72	PSS - Adult Mental Health
22	PSS - Family Support
11	PSS - Youth Support
3	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
WASHINGTON	**WORKER TYPE**
149	PSS - Adult Addictions
55	PSS - Adult Addictions & Mental Health
204	PSS - Adult Mental Health
49	PSS - Family Support
32	PSS - Youth Support
16	PWS - Adult Addictions
29	PWS - Adult Addictions & Mental Health
83	PWS - Adult Mental Health
1	PWS - Youth Support
3	PWS - Family Support

PEER WORKER TYPES BY COUNTY

WHEELER	WORKER TYPE
42	PSS - Adult Addictions
15	PSS - Adult Addictions & Mental Health
63	PSS - Adult Mental Health
17	PSS - Family Support
8	PSS - Youth Support
3	PWS - Adult Addictions
4	PWS - Adult Addictions & Mental Health
18	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

PEER WORKER TYPES BY COUNTY	
YAMHILL	**WORKER TYPE**
74	PSS - Adult Addictions
31	PSS - Adult Addictions & Mental Health
111	PSS - Adult Mental Health
30	PSS - Family Support
9	PSS - Youth Support
6	PWS - Adult Addictions
10	PWS - Adult Addictions & Mental Health
26	PWS - Adult Mental Health
1	PWS - Youth Support
0	PWS - Family Support

Appendix L: State-approved training programs by county and type

Data derived by publicly available OHA list of current THW certification training programs on September 8, 2020.

CURRENT STATE-APPROVED PEER CERTIFICATION TRAINING PROGRAMS	
COUNTY	**TRAINING TYPE**
Coos	PSS - Addictions
Douglas	PSS - Addictions
Jackson	PSS - Addictions
Jackson	PSS - Addictions
Jackson	PSS - Addictions
Jackson	PSS - Addictions
Lane	PSS - Addictions
Lane	PSS - Addictions & Mental Health
Marion	Family Support Specialist
Marion	PSS - Addictions
Marion	PSS - Youth Support Specialist (Addictions)
Multnomah	PSS - Addictions
Multnomah	PSS - Addictions
Multnomah	PSS - Addictions
Multnomah	PSS - Addictions (focus on transition-aged youth)
Multnomah	PSS - Mental Health
Multnomah	PWS - Addictions & Mental Health
Multnomah	PWS - Family Support
Multnomah	PWS - Mental Health
Umatilla	Family Support Specialist
Washington	PSS - Addictions & Mental Health

COUNTY	NUMBER OF TRAINING PROGRAMS
Multnomah	8
Umatilla	1
Jackson	4
Douglas	1
Marion	3
Lane	2
Washington	1
Coos	1

TYPE OF TRAINING	COUNT
Family Support Specialist	2
PSS - Addictions	12
PSS - Addictions & Mental Health	2
PSS - Mental Health	1
Youth Support Specialist - Addictions	1
PWS - Family Support	1
PWS - Mental Health	1
PWS - Addictions & Mental Health	1

OREGON HEALTH AUTHORITY,
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

DIVISION 180
TRADITIONAL HEALTH WORKERS

410-180-0300
Purpose

These rules establish the criteria for training, certification and enrollment of traditional health workers (THW) in a registry maintained by the Oregon Health Authority (Authority). THWs include community health workers, personal health navigators, peer wellness specialists, peer support specialists and birth doulas not otherwise regulated or certified by the state of Oregon. These rules also establish curriculum requirements and procedures for Authority approval of programs seeking to train Oregon's traditional health workers.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0305
Definitions

The following definitions apply to OAR 410-180-0300 through 410-180-0380:
(1) "Authority" means the Oregon Health Authority.
(2) "Authority approved training program" means an organization that provides and education in the core curriculum that meets Authority standards for one or more types of traditional health workers and has been approved by the Authority to train those types of traditional health workers.
(3) "Birth doula" means a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience.
(4) "Birth doula certification organization" means an entity nationally or internationally recognized for training and certifying birth doulas whose educational requirements includes the core curriculum topics described in these rules.
(5) "Community based organization" (CBO) means a public or private nonprofit organization that is representative of a community or significant segments of a community and engaged in meeting that community's needs in the areas of social, human, or health services.
(6) "Community health worker" has the meaning given that term in ORS 414.025.
(7) "Contact hour" means an hour of classroom, group or distance learning training. Contact hour does not include homework time, preparatory reading, or practicum.
(8) "Competencies" mean key skills and applied knowledge necessary for THWs to be effective in the work field and carry out their roles.
(9) "Equivalent credit" means an individual has fulfilled the requirements of a course or combination of courses, by completing a relatively comparable course or combination of courses.
(10) "Grandfathered traditional health worker" means an individual certified before June 30, 2019 by the Authority as a result of their prior work experience and fulfillment of all additional requirements for grandfathering as set forth in these rules.

(11) “Peer support specialist” means an individual providing services to another individual who shares a similar life experience with the peer support specialist (addiction to addiction, mental health condition to mental health condition, family member of an individual with a mental health condition to family member of an individual with a mental health condition, young adult to young adult). A peer support specialist shall be:
(a) A self-identified individual currently or formerly receiving addictions or mental health services;
(b) A self-identified individual in recovery from an addiction disorder, who meets the abstinence requirements for recovering staff in alcohol or other drug treatment programs;
(c) A self-identified individual in recovery from problem gambling; or
(d) The family member of an individual currently or formerly receiving addictions or mental health services.
(12) “Peer wellness specialist” has the meaning given that term in ORS 414.025.
(13) “Personal health navigator” has the meaning given that term in ORS 414.025.
(14) "Registry" means a list maintained by the Authority of traditional health workers certified under these rules.
(15) "THW applicant" means an individual who has applied to the Authority for traditional health worker certification.
(16) “Traditional health worker” (THW) means a community health worker, peer wellness specialist, personal health navigator, peer support specialist, or birth doula not otherwise regulated or certified by the state of Oregon.
(17) “Training program applicant” means an organization or entity that has applied for Authority approval of its training program and curricula for any of the traditional health worker types.
(18) “Verifiable evidence” means a pay statement, services contract, student practicum, volunteer time log or other documentation reflecting hours worked or volunteered.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0310
Community Health Worker, Peer Wellness Specialist, Personal Health Navigator Certification Requirements
(1) To be certified as a community health worker, peer wellness specialist, or personal health navigator, an individual shall:
(a) Complete all required training offered by an Authority approved training program for that individual’s traditional health worker (THW) type.
(b) Complete an Authority approved oral health training.
(c) Complete all application requirements to be in the state registry;
(d) Complete the Authority certification process; and
(e) Be successfully accepted into the state registry.
(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body, may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0312
Peer Support Specialist Certification Requirements
(1) To be certified as a peer support specialist, an individual shall:
(a) Complete all required training offered by an Authority approved training program for peer support specialists;
(b) Complete an Authority approved oral health training.
(c) Complete all application requirements to be in the state registry;
(d) Complete the Authority certification process; and
(e) Be successfully accepted into the state registry.
(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body, may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0315
Birth Doula Certification Requirements
(1) To be certified as a birth doula, an individual shall:
(a) Complete all required training specified in OAR 410-180-0375 through:
(i) An Authority approved birth doula training program; or
(ii) A combination of programs that results in meeting all the requirements through equivalent credit.
(b) Complete an Authority approved oral health training.
(c) Be CPR-certified for children and adults.
(d) Create a community resource list on an Authority approved form.
(e) Document attendance at a minimum of three births and three postpartum visits using an Authority approved form.
(f) Complete all application requirements to be in the state registry;
(g) Complete the Authority certification process; and
(h) Be successfully accepted into the state registry.
(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body, may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0320
Traditional Health Worker Continuing Education Requirements
(1) To maintain certification status, all THWs shall complete at least 20 hours of Authority approved continuing education during every three year renewal period.
(2) Continuing education hours taken in excess of the total number required may not be carried over to the next renewal period.
(3) Requests for approval of continuing education courses may come from the hosting organization or from a certified THW attending the training or event.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0325
Application and Renewal Process for Traditional Health Worker (THW) Certification and Registry Enrollment
(1) Individuals seeking THW certification and registry enrollment shall:
(a) Be at least 18 years of age;
(b) Not be listed on the Medicaid provider exclusion list;
(c) Successfully complete all training requirements for certification in a traditional health worker category as outlined in these rules;
(d) Pass a background check as described in OAR 410-180-0326;
(e) Beginning October 1, 2017, successfully complete an Authority approved oral health training;
(f) Submit to the Authority all required documentation and a completed application on an Authority prescribed form;
(2) An individual applying for certification or renewal as a peer support specialists as that term is defined in OAR 410-180-0305(11)(b), (c) may have their background check completed by an outside entity pursuant to 410-180-0326 and be certified by that entity.
(a) The entity's certification requirements shall include all peer support specialists certification and renewal requirements set forth in these rules.
(b) For Authority certification or renewal and entry into the registry, peer support specialists shall either:
(A) Have the outside entity submit their certification and background check information to the Authority; or
(B) Submit to the Authority all required documentation and a completed application on an Authority prescribed form.
(2) Individuals seeking THW certification and registry enrollment as a grandfathered community health worker, peer wellness specialist, personal health navigator, or peer support specialist shall:
(a) Be at least 18 years of age;

(b) Not be listed on the Medicaid provider exclusion list;
(c) Pass a background check as described in OAR 410-180-0326;
(d) Submit to the Authority all required documentation and a completed application on an Authority prescribed form by June 30, 2019 including;
(i) A minimum of one letter of recommendation from any previous employer for whom THW services were provided between January 1, 2008 and June 30, 2016; and
(ii) Verifiable evidence of working or volunteering in the capacity of a community health worker, peer wellness specialist, or personal health navigator for at least 3000 hours between January 1, 2008 to June 30, 2016; or
(iii) Verifiable evidence of working or volunteering in the capacity of a peer support specialist for at least 2000 hours between January 1, 2008 and June 30, 2016;
(3) Registry applications are available on the THW program webpage or by request to the Oregon Health Authority Office of Equity and Inclusion.
(4) An individual may withdraw from the application process for certification and enrollment or from the registry by submitting written notification to the Authority unless a complaint investigation or revocation proceeding is underway.
(5) Except for birth doulas, applicants shall apply for certification within three years of completing a training program to be eligible for certification and registry enrollment.
(6) Except for birth doulas, applicants denied certification because they completed a training program more than three years prior to application may file an appeal with the Authority for an exemption.
(7) If the Authority determines that an applicant has met the requirements of this section, the Authority shall notify the applicant in writing granting the individual certification as a THW and add the individual to the registry.
(8) Certification is valid for 36 months from the date of certification.
(9) A THW seeking certification renewal shall:
(a) Submit a completed renewal application on an Authority prescribed form, no less than 30 days before the expiration of the current certification period;
(b) Pass a background check as described in OAR 410-180-0326;
(c) Provide written verification indicating that the certificate holder has met the applicable requirements for continuing education set forth in OAR 410-180-0320; and
(d) During the renewal period occurring between October 2017 and October 2020:
(i) Complete Authority approved oral health training; and
(ii) Submit proof of completion with their renewal application.
(12) The Authority shall remove a THW from the registry if the THW fails to renew certification within the renewal period.
(13) THWs removed from the registry following certification expiration shall be denied renewal unless they file an appeal with the Authority within 60 calendar days of certification expiration and are granted an exemption.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 3-2014, f. & cert. ef. 1-15-14

410-180-0326

Background Check Requirements
(1) For all new or renewal applications for THW certification, the Authority shall:
(b) Conduct a background check in accordance with 943-007-0010 through 0501 specifically incorporating and limited to 407-007-0200 to 407-007-0250, and 407-007-0340 to 407-007-0370 and expressly not incorporating 407-007-0275 and 407-007-0277.
(b) Consult with the Office of the Inspector General to determine if the applicant is excluded from participation in the medical assistance program.
(2) New or renewal THW applicants may be denied certification or renewal of certification based on a fitness determination that applies a weighing test for potentially disqualifying convictions or conditions.
(3) New or renewal THW applicants shall be denied certification if they are excluded from participating in the medical assistance program.
(4) To be certified, enrolled in the registry, and eligible for reimbursement under Medicaid, peer support specialists as defined in OAR 410-180-0305(11)(b) and (c) are required to pass a background check. The background check may be conducted by the Authority or by an entity contracting with the Authority to provide background checks.
(a) If the Authority conducts the background check, the Authority's fitness determination shall comply with the provision of section (1) and shall include the application of a weighing test for potentially disqualifying convictions or conditions.
(b) If a contracting entity conducts the background check, the provisions of 407-007-0277 shall apply.
(c) Peer support specialists described in this section may choose which entity conducts the background check.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 181.537, 414.635 & 414.665
Hist.: DMAP 3-2014, f. & cert. ef. 1-15-14

410-180-0340
Standards of Professional Conduct
(1) An Authority certified THW, shall comply with Standards of Professional Conduct set forth in this rule. The violation of the standards may result in the suspension or revocation of certification or denial of an application for renewal.
(2) THWs shall:
(a) Acquire, maintain and improve professional knowledge and competence using scientific, clinical, technical, psychosocial, governmental, cultural and community-based sources of information.
(b) Represent all aspects of professional capabilities and services honestly and accurately.
(c) Ensure that all actions with community members are based on understanding and implementing the core values of caring, respect, compassion, appropriate boundaries, and appropriate use of personal power.
(d) Develop positive collaborative partnerships with community members, colleagues, and other health care providers to provide care, services, and supports that are safe, effective, and appropriate to a community member's needs.
(e) Regardless of clinical diagnosis, develop and incorporate respect for diverse community member backgrounds when planning and providing services, including lifestyle, sexual

orientation, race, gender, ethnicity, religion, age, marital status, political beliefs, socioeconomic status or any other preference or personal characteristic, condition or state.
(f) Act as an advocate for community members and their needs.
(g) Support self-determination for community members in a culturally competent, trauma informed manner.
(h) Make decisions and act based on sound ethical reasoning and current principles of practice in a way that supports empowerment and respect for community members' culture and self-defined health care goals.
(i) Maintain individual confidentiality.
(j) Comply with laws and regulations involving mandatory reporting of harm, abuse, or neglect while making every effort to involve the individuals in planning for services and ensuring that no further harm is done to family members as the result of the reporting.
(k) Recognize and protect an individual's rights as described in section (3) of this rule.
(3) Individuals have the right to:
(a) Dignity and respect;
(b) Freedom from theft, damage, or misuse of personal property;
(c) Freedom from neglect and abuse, whether verbal, mental, emotional, physical, or sexual;
(d) Freedom from financial exploitation;
(e) Freedom from physical restraints;
(f) Freedom from discrimination in regard to race, color, national origin, disability, gender, sexual orientation, socioeconomic status, size, type of diagnosis criminal history or religion;
(g) Confidentiality of their information and records; and
(h) To give voice to grievances or complaints regarding services or any other issue without discrimination or reprisal for exercising their rights;

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0345
Denial, Suspension or Revocation of Certification
(1) The Authority may deny, suspend, or revoke certification when an applicant or certificate holder fails to comply with these rules.
(2) The Authority shall deny, suspend, or revoke certification pursuant to ORS 183.411 through 183.470 and the applicant or certificate holder may request a contested case hearing.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0350
Training Program Requirements
(1) All Authority approved training programs shall:
(a) Meet the curriculum requirements for the THW type being trained.

(b) Demonstrate active efforts to establish equivalency for students who have previously completed training that meets one or more training requirements for their THW type.
(c) Require experienced THWs be involved in developing and teaching the core curriculum.
(d) Be a culturally diverse community based organization (CBO) or include collaboration with at least one culturally diverse CBO.
(e) Demonstrate the use of various teaching methodologies, including but not limited to popular education and adult learning;
(f) Demonstrate the use of various training delivery formats, including but not limited to classroom instruction, group, and distance learning.
(g) Demonstrate efforts to make training inclusive and accessible to individuals with different learning styles, education backgrounds, and needs.
(h) Demonstrate efforts to remove barriers to enrollment for students.
(i) Include any combination of written, oral or practical cognitive examinations to evaluate and document the acquisition of knowledge and mastery of skills required by the curriculum designed to instruct in the THW competencies.
(j) Demonstrate the inclusion of a method or process for individuals trained by the program to evaluate and give feedback on the training experience.
(k) Maintain an accurate record of each individual's attendance and participation in training for at least five years after course completion.
(l) Agree to verify and provide the Authority with names of individuals who successfully completed the training program when those individuals apply for certification and registry enrollment.
(m) Agree to issue a certificate of completion to all successful training program graduates.
(2) Individuals or entities applying to become an Authority approved training program shall submit information to the Authority that includes at minimum:
(a) Contact information for the individual or entity, including director name and contact information;
(b) Syllabus and course materials that demonstrate the curriculum covers the required competencies;
(c) Indication of the training type and curriculum, including specialized training to be offered for community health workers, peer wellness specialists, peer support specialists, personal health navigators, and birth doulas;
(d) An overview of the teaching philosophy and methodology;
(e) A description of the method of final examinations;
(f) A list of instructors, including experienced THWs;
(g) A description of the geographic area served;
(h) A signed agreement describing a CBO partnership, if the applicant is not a CBO;
(i) A description of the approach for recruiting and enrolling a diverse student population to meet the needs of the community, including any strategies for reducing barriers to enrollment; and
(j) An indication of whether academic credit may be given for successful completion of training program.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0355
Application and Renewal Process for Authority Training Program Approval
(1) Training program applications are available on the THW program webpage or by request from the Oregon Health Authority Office of Equity and Inclusion.
(2) Training program applicants shall submit an application at least 90 days in advance of the first expected class day.
(3) If an application is incomplete, the Authority shall send notice requesting the additional materials required.
(a) The notice shall specify the date by which additional materials must be submitted.
(b) Unless an extension is granted, the Authority shall return the application and take no further action if the applicant does not respond within the specified time frame.
(4) If the Authority determines that an applicant has met all training program requirements, the Authority shall send written notice of program approval.
(5) Written notice of Authority approval shall be made available to any student or partnering organization upon request.
(6) The Authority shall maintain and make available to the public a list of approved training programs.
(7) Training programs shall apply for renewed approval status every three years.
(a) Renewal applications are available on the THW program webpage or by request from the Oregon Health Authority Office of Equity and Inclusion.
(b) Training programs shall complete and submit the renewal application no less than six months prior to the expiration of the current approval period.
(8) Training programs seeking renewal shall provide at a minimum:
(a) A summary of any proposed changes to the curriculum; and
(b) The number of students trained in the three year approval period
(9) Training programs that fail to submit a renewal application at least six months before their renewal date will be required to submit a new application rather than apply for renewal.
(10) The Authority may conduct site visits of training programs, either prior to approving or renewing a training program application, or at any time during the three year approval period.
(11) Any change made to an approved training program shall be reported to the Authority within 30 days of the decision, including:
(a) Changes to the:
(A) Training program director or primary contact;
(B) Teaching methodology;
(C) Curriculum; or
(b) Any change not consistent with or represented in the initial application for approval.
(12) If the Authority determines that the reported changes meet the training program requirements described in OAR 410-180-0350, the Authority shall approve the change.
(a) The Authority may request additional information and justification for the reported change.
(b) If the Authority determines that the reported changes do not comply with the training program requirements described in OAR 410-180-0350, the Authority may deny the change or revoke training program approval.
(13) A training program applicant or approved training program may request a temporary waiver from a requirement in these rules. A request for a waiver shall:
(a) Be submitted to the Authority in writing;

(b) Identify the specific rule for which a waiver is requested;
(c) Identify the special circumstances relied on to justify the waiver;
(d) Describe alternatives that were considered, if any, and why alternatives, including compliance, were not selected;
(e) Demonstrate that the proposed waiver is desirable to maintain or improve the training of THWs; and
(f) Indicate the proposed duration of the waiver, not to exceed one year.
(14) If the Authority determines that the applicant or program has satisfied the conditions of this rule, the Authority may grant a waiver.
(15) An applicant or an approved training program may not act on or implement a waiver until it has received written approval from the Authority.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0360
Denial, Suspension or Revocation of Training Program Approval
(1) The Authority may deny, suspend or revoke training program approval when an applicant or approved program has failed to comply with statute or these rules.
(2) If the Authority denies, suspends, or revokes approval it shall send written notice and explain the basis for its decision.
(3) An applicant or approved training program may request that the Authority reconsider its decision and may request a meeting with Authority staff.
(a)The request for reconsideration and a meeting, if requested, shall be submitted in writing within 30 days of the date the Authority mailed the written decision of denial, suspension or revocation.
(b) The request shall contain a detailed statement with supporting documentation explaining why the requestor believes the Authority's decision is in error.
(4) The Authority shall issue a written decision on reconsideration following review of the materials submitted by the applicant or training program and a meeting with the applicant or training program, if applicable.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0365
Oral Health Training Requirements
(1) The Authority shall approve oral health training that includes coursework in:
(a) Basic dental anatomy;
(b) Caries and periodontal disease process;
(c) Infection and communicable disease;
(d) Basic oral hygiene and disease prevention for different ages; and

(e) Healthcare system navigation, access and coverage, including Medicaid
(2) The Authority shall include members of the dental care community in the development of requirements for and approval of Authority approved oral health training.
(3) Individuals or entities creating or providing oral health training for approval by the Authority are not required to meet the full qualifications of a training program outlined in OAR 410-180-0350.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0370
Community Health Workers, Peer Wellness Specialists, Personal Health Navigators, and Peer Support Specialists Certification Curriculum Standards
(1) All community health workers, peer wellness specialists and personal health navigators shall receive training from an Authority approved training program whose curriculum includes:
(a) A minimum of 80 contact hours addressing the core curriculum set forth in section (2) of this rule and any additional curriculum topics specific to the type of worker being trained.
(b) All the major roles and core competencies listed and defined in the Oregon Health Policy Board Report "The Role of Non-Traditional Health Workers in Oregon's Health Care System". (https://www.oregon.gov/oha/oei/Documents/nthw-report-120106.pdf)
(2) An Authority approved core curriculum for community health workers, peer wellness specialists and personal health navigators shall, at a minimum, introduce students to the key principles of the following topics:
(a) Community engagement, outreach methods and relationship building;
(b) Communication, including cross-cultural communication, active listening, and group and family dynamics;
(c) Empowerment techniques;
(d) Identification of community resources;
(e) Cultural competency and cross-cultural relationships, including bridging health system and community cultures;
(f) Conflict identification and problem solving;
(g) Conducting individual strength and needs based assessments;
(h) Advocacy;
(i) Ethical responsibilities in a multicultural context;
(j) Legal responsibilities;
(k) Crisis identification and problem-solving;
(l) Professional conduct, including culturally appropriate relationship boundaries and maintaining confidentiality;
(m) Navigating public and private health and human service systems, including state, regional, and local systems;
(n) Working with caregivers, families, and support systems, including paid care workers;
(o) Trauma-informed care, including screening and assessment, recovery from trauma, and minimizing re-traumatization;
(p) Self-care;

(q) Social determinants of health;
(r) Building partnerships with local agencies and groups;
(s) The role and certified scope of practice for traditional health workers;
(t) Roles, expectations, and supervisory relationships for working in multidisciplinary teams, including supervisory relationships;
(u) Data collection and types of data;
(v) Organization skills, documentation and use of health information technology;
(w) Introduction to disease processes, including chronic diseases, mental health, tobacco cessation, and addictions, including warning signs, basic symptoms, and when to seek medical help;
(x) Health across the life-span;
(y) Adult learning principles, including teaching and coaching;
(z) Stages of change;
(aa) Best practices for health promotion; and
(bb) Health literacy issues.
(3) In addition to the core curriculum set forth in section (2) of this rule, training programs for community health workers shall include the following topics:
(a) Self-efficacy;
(b) Community organizing;
(c) Group facilitation skills;
(d) Conducting community needs assessments;
(e) Popular education methods; and
(f) Principles of motivational interviewing.
(4) In addition to the core curriculum, set forth in section (2) of this rule, training programs for peer wellness specialists shall include the following topics:
(a) Self-efficacy;
(b) Group facilitation skills;
(c) Cultivating individual resilience;
(d) Recovery, resilience and wellness models; and
(e) Principles of motivational interviewing.
(5) An Authority approved curriculum for peer support specialists shall include a minimum of 40 contact hours that include:
(a) The core curriculum set forth in section (2)(a) through (p);
(b) The role and scope of practice for peer support specialists; and
(c) Recovery, resilience and wellness.
(6) An Authority approved curriculum for family support specialists and youth support specialists shall include the following topics:
(a) The role of the family support specialist and youth support specialist in the system serving children and youth;
(b) Collaborative problem solving;
(c) Protective factors and developmental assets to promote resilience; and
(d) Multi-systems services and payment navigation.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0375
Birth Doula Certification Curriculum Standards
(1) All birth doulas seeking certification with the state shall complete a minimum of 40 contact hours that include the following:
(a) A minimum of 28 in-person contact hours addressing the core curricula topics set forth in section (2) of this rule through an Authority approved training program for birth doulas or through another training program provided by a birth doula certification organization;
(b) Six contact hours in cultural competency training; and
(c) Six contact hours in one or more of the following topics as they relate to doula care:
(A) Inter-professional collaboration;
(B) Health Insurance Portability and Accountability Act (HIPAA) compliance; and
(C) Trauma-informed care.
(2) All core curriculum for training birth doulas shall, at a minimum, introduce students to the key principles of the following topics:
(a) Anatomy and physiology of labor, birth, maternal postpartum, neonatal transition, and breastfeeding;
(b) Labor coping strategies, comfort measures and non-pharmacological techniques for pain management;
(c) The reasons for, procedures of, and risks and benefits of common medical interventions, medications, and Cesarean birth;
(d) Emotional and psychosocial support of women and their support team;
(e) Birth doula scope of practice, standards of practice, and basic ethical principles;
(f) The role of the doula with members of the birth team;
(g) Communication skills, including active listening, cross-cultural communication, and inter-professional communication;
(h) Self-advocacy and empowerment techniques;
(i) Breastfeeding support measures;
(j) Postpartum support measures for the mother and baby relationship;
(k) Perinatal mental health;
(l) Family adjustment and dynamics;
(m) Evidence-informed educational and informational strategies;
(n) Community resource referrals;
(o) Professional conduct, including relationship boundaries and maintaining confidentiality; and
(p) Self-care.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

410-180-0380
THW and Training Program Complaints and Investigations
(1) Any individual may make a complaint to the Authority, verbally or in writing about the:
(a) Care or services provided by a certified THW;
(b) Violation of statutes or these rules by an approved THW training program.

(2) The identity of an individual making a complaint shall be kept confidential to the extent allowed by law but may be disclosed as necessary to conduct the investigation; this may include disclosing the complainant's identity to the THW's employer.
(3) If a complaint involves an allegation of criminal conduct or conduct within the jurisdiction of another local, state, or federal agency, the Authority shall refer the matter to the appropriate agency.
(4) The Authority shall investigate complaints and take any actions that are necessary for resolution. An investigation may include but is not limited to:
(a) Interviews of the complainant, program management or staff, and students;
(b) Interviews of the complainant, caregivers, THW clients, client representatives, client family members, witnesses, and employer management and staff;
(c) On-site observations of the training program, the client, THW performance and client environment; and
(d) Review of documents and records.
(5) The Authority may utilize complaint and investigation findings to identify trends and potential areas for quality improvement.
(6) The results of complaint investigation may be published to the public by the Authority.

Stat. Auth.: ORS 413.042, 414.635 & 414.665
Stats. Implemented: ORS 414.635 & 414.665
Hist.: DMAP 42-2013(Temp), f. & cert. ef. 8-2-13 thru 1-29-14; DMAP 66-2013, f. & cert. ef. 12-3-13

Appendix M: Milestones of the Consumer/Survivor/Ex-patient (C/S/X) Movement for Social Justice - Developed for the ADA Legacy Project by Susan Rogers, Pat Risser, and others (accessed from https://www.ncmhr.org/downloads/ADA-Legacy-Project-Mental-Health-CSX-Movement-History-Milestones.pdf)

Milestones of the Consumer/Survivor/Ex-patient (C/S/X) Movement for Social Justice

The consumer/survivor/ex-patient movement has a rich and complex history, and it is impossible to tell the story using only 10 milestones. These milestones are intended only as an introduction and it is hoped that the reader will delve further into the history of the c/s/x movement. (In the milestones below, c/s/x movement activists will be referred to by various names, such as peers.)

1969: The Insane Liberation Front (ILF) is organized by Howie the Harp, Dorothy Weiner and Tom Wittick in Portland, Oregon. It is the first-known modern self-help/advocacy group organized by ex-patients and dedicated to liberation from psychiatry. Subsequently, similar groups were founded around the country, including Mental Health Consumer Concerns, founded in 1977 by Jay Mahler in Contra Costa County, California, which is the oldest c/s/x-run organization in continuous operation in the U.S. Today, there are numerous such organizations in nearly every state and territory, including varied and sophisticated models, such as peer-run crisis respites – some of which are modeled after Soteria House, created in 1971. Many of these organizations publish newsletters and other materials. The first-known national publication of the c/s/x movement is Madness Network News, which published its first edition in 1972.

1973: The first of 13 annual International Conferences on Human Rights and Against Psychiatric Oppression is held at the University of Detroit. The last one was held in Vermont in 1985. These conferences led to the creation of the Alternatives conferences.

1975: The U.S. Supreme Court, in *O'Connor v. Donaldson*, rules that people cannot be institutionalized against their will in a psychiatric hospital unless they are determined to be a threat to themselves or to others. Also, *Rogers v. Macht* (*Rogers v. Okin* or *Rogers v. Commissioner of Mental Health*) is filed and was finally adjudicated in 1982; this ruling established a limited right to refuse treatment (psychiatric drugs) in Massachusetts. In addition, in 1975, the book *One Flew Over the Cuckoo's Nest,* by Ken Kesey, was made into an award-winning movie starring Jack Nicholson. The movie drew attention to the horrors of mental illness treatment.

1978: *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, by Judi Chamberlin, is published by McGraw-Hill. It becomes a standard text of the c/s/x movement.

1979: Loren Mosher, chief of schizophrenia studies at the National Institute of Mental Health (NIMH), reports superior one-year and two-year outcomes for Soteria House patients treated without neuroleptics.

1980: The Civil Rights of Institutionalized Persons Act (CRIPA) gives the Department of Justice the power to sue state or local institutions that violate the rights of people held against their will, including those residing in institutions for the treatment of mental illnesses.

1984: The Committee for Truth in Psychiatry, an organization of survivors of electroconvulsive therapy, is organized by shock survivors Marilyn Rice and Linda Andre. Subsequently, "[f]or the first time, a product liability suit against a shock machine manufacturer . . . resulted in a successful settlement for the plaintiffs. The suit was brought by Imogene Rohovit of Iowa City, Iowa, and her daughters, alleging that Mrs. Rohovit, a single mother and former nurse, has been brain damaged and rendered unable to work by shocks inflicted by the MECTA Model D machine in 1989." http://www.ect.org/news/suit.html In 2009, Rutgers University Press published *Doctors of Deception: What They Don't Want You to Know About Shock Treatment*, by Linda Andre. The c/s/x movement has also organized to end the practice of

seclusion and restraint, and there has been progress in this regard. For example, former SAMHSA administrator Charles G. Curie, when he served as Pennsylvania's top mental health official, instituted a policy of moving toward the complete elimination of seclusion and restraint in state hospitals.

1985: The first annual Alternatives conference, in Baltimore, Maryland, is organized by On Our Own of Baltimore and funded by the National Institute of Mental Health-Community Support Programs. These conferences have been held nearly annually ever since; Alternatives 2012 is the 26th Alternatives conference.

1985: At Alternatives '85, the National Mental Health Consumers' Association – the first national c/s/x organization – is founded under the leadership of Joseph Rogers. At a meeting of the organization in Pottstown, Pennsylvania, in 1986, five steering committee members left to form the National Alliance of Mental Patients (later the National Association of Psychiatric Survivors). The schism proved fatal to both organizations, and both are now defunct. A people-of-color caucus first met at Alternatives '92, in Philadelphia; at Alternatives '94, the caucus organized more formally as a national organization of people of color in the c/s/x movement. Altered States of the Arts – founded through the leadership of Gayle Bluebird, Howie the Harp, Dianne Cote and Sally Clay – was founded at Alternatives '90. Support Coalition International (now MindFreedom International) was also founded in 1990.

1986: The first c/s/x-run national technical assistance center – the National Mental Health Consumers' Self-Help Clearinghouse – is founded by Joseph Rogers in Philadelphia to serve the c/s/x movement. Today, the Substance Abuse and Mental Health Services Administration provides funding through a competitive grant process for three c/s/x-run national technical assistance centers and two c/s/x-supporter national technical assistance centers.

1986: The passage of the State Comprehensive Mental Health Plan Act (P.L. 99-660) mandates "the provision of case management services to each chronically mentally ill individual in the states who receives substantial amounts of public funds or services." This established case management as a distinct benefit under Medicaid. Medicaid amendments improved mental health coverage of community mental health services, added rehabilitative services, and expanded clinical services to individuals who were homeless. P.L. 99-660 also requires stakeholder involvement in the State Block Grant program, thus acknowledging the importance of the voice of the users of services. Also, Congress passed the Protection and Advocacy for Mentally Ill Individuals (now called the Protection and Advocacy for Individuals with Mental Illness) Act of 1986 (P.L. 99-319; 42 U.S.C. 10801 et seq.), designed to extend to individuals with mental illnesses in institutions the services of the protection and advocacy agencies that had previously been established to safeguard the rights of individuals with developmental disabilities.

1986: The first peers (including award-winning movement activist Pat Risser) are trained to work for the mental health system as professionals – Consumer Case Manager Aides – in Denver, Colorado, through the leadership of Paul Sherman, Ph.D. The services of these peer providers were billable to Medicaid under the Medicaid Rehabilitation Option Waiver in effect for Colorado. This was the precursor to the successful effort in 2001 by the Georgia Mental Health Consumer Network, under the leadership of Larry Fricks, to obtain approval from the Centers for Medicare & Medicaid Services (CMS) to bill Medicaid for peer support services. Many states have followed suit, and the profession of peer specialist has burgeoned. This includes the creation, in 2004, of the National Association of Peer Specialists, through the leadership of Steve Harrington.

1990: The Americans with Disabilities Act, a landmark civil rights law that prevents discrimination based on disability, is passed. Joseph Rogers, a leader of the c/s/x movement, served on the Congressionally appointed Task Force on the Rights and Empowerment of Americans with Disabilities, which – under the leadership of Justin Dart,* known as the father of the ADA – helped pass the bill. In 1999, the U.S. Supreme Court, in *Olmstead v. L.C.,* 527 U.S. 581, upheld the community integration mandate of the ADA by ruling that it is a violation of the law to keep individuals in restrictive inpatient settings when more appropriate community services are available.

1998-2004: The Consumer-Operated Services Program Multi-Site Research Initiative studied – and proved – the effectiveness of peer-run programs. Jean Campbell, Ph.D., a c/s/x movement activist and researcher, is the organizer of this initiative, and her pioneer efforts have led to other research studies of c/s/x-run programs. As a result, peer support is an evidence-based practice.

2003: The report of the President's New Freedom Commission on Mental Health declares "that America's mental health service delivery system is in shambles," leading to unnecessary and costly disability, homelessness, school failure and incarceration. The Commission recommended fundamentally transforming how mental health care is delivered in the United States with a primary goal of recovery for everyone. The Commission further stated that the transformed system must be consumer- and family-driven. Dan Fisher. M.D., Ph.D., a leader of the c/s/x movement, served on the Commission, ensured that a variety of peer voices were heard, and was influential in the report.

2006: The National Coalition of Mental Health Consumer/Survivor Organizations (now the National Coalition for Mental Health Recovery) was founded through the leadership of Dan Fisher, M.D., Ph.D. This organization, comprising statewide c/s/x networks as well as associate and individual members, is a national voice of the c/s/x movement.

2012: The Substance Abuse and Mental Health Services Administration (SAMHSA) appoints Paolo del Vecchio, an individual with a mental health condition who began working at SAMHSA in 1995, as director of the Center for Mental Health Services, the federal mental health authority.

*At the Second National Summit of Mental Health Consumers and Survivors, **Justin Dart**, one of the heroes of the disability rights movement who is known as the father of the ADA, said, "One of the first priorities of the empowerment society will be real rights for all – including people with psychiatric disabilities and psychiatric survivors. We must create and enforce laws that abolish the persecution which we suffer every day in every aspect of life. We must abolish involuntary confinement, physical and psychological abuse, coercion, outpatient commitment, and forced treatment of any kind.

"But rights are only the beginning. We must guarantee to each person – with and without a psychiatric disability – the tools to create the good life. I speak of the obvious: quality food, shelter, education, technology, and comprehensive health care, INCLUDING FULL, CONSUMER-CONTROLLED SERVICES FOR PSYCHIATRIC DISABILITIES. And much more: we must guarantee a society of choice and of reinforcement for positive contributions. WE MUST CREATE A SOCIETY OF PROFOUND LOVE FOR EACH HUMAN LIFE. LOVE, EMPOWERS A THOUSAND TIMES MORE THAN ANY DRUG EVER MADE.

"Colleagues, this is a powerful agenda. But can we win against the forces of ancient stigma and billion-dollar politics? Not quickly, not easily, and not simply by appealing to government. We must BECOME GOVERNMENT through elective and appointed office and voluntary action. We must create a politics in which government will be forced to empower. WE must carry the fight to the media and to the people in

every community. We must reframe the public dialogue. We must make the empowerment of all the first issue of American politics. The time has come to shout, "NO MORE SECOND-CLASS CITIZENS!" "AMERICA FOR ALL!"

“Colleagues, I know that YOU are already good soldiers. But we must increase our tiny army ten thousand percent. And we can do it. A relatively small constituency of people with HIV-AIDS overcame massive stigma to become a real force. If they can do it, we can do it.

“The community of people with psychiatric disabilities and of psychiatric survivors is by far the largest constituency among people with disabilities. There are tens of millions of us. We have members who are geniuses, who are millionaires, who are stars of sports and entertainment, who are leaders of government, business, science, academia and religion. We have the potential to be one of the most powerful forces in the culture. But it's not going to happen until WE unite and until WE organize.

“Colleagues, this is very personal to me. I have suffered depression, still do. My beautiful mother, my only brother and two other members of my family with psychiatric disabilities have taken their own lives rather than face the daily persecution.

“Each one of you has experienced atrocity – many far worse than I have. We experience physical and psychological holocaust.

“Let us rise above our differences. Let us lift our eyes to the dream. Let us embrace each other in that most profound love for the sacred value of each human life. Let us unite in passionate action. No soldier ever died in a better cause.”