PEER RECOVERY COACH (RC)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations, and all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

OVERVIEW

Peer Recovery Coach (RC) are individuals currently in sustained recovery, for two or more years, who have lived experience with addiction and/or co-occurring mental health disorders and have been trained to help their peers with a similar experience to gain hope, explore recovery and achieve life goals. RCs are actively engaged in their own personal recovery and share real-world knowledge and experience with others who are on their own recovery path. RCs share their recovery story and personal experiences to establish an equitable relationship and support Enrollees in obtaining and maintaining recovery.

The primary responsibility of a RC is to support the voices and choices of the Enrollees they support, minimizing the power differentials as much as possible. The focus of the RC role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking Enrollees to a recovery community and serving as a personal guide and mentor. When appropriate, an RC may develop a recovery or wellness plan with the Enrollee to support the Enrollee in their pathway of recovery. The wellness plan may be shared for documentation purposes, with the Enrollee's consent.

Enrollees can access RC services based on medical necessity and a referral by a medical or behavioral health provider, Community Partner (CP), or other care manager, that has contact with the Enrollee and is able to identify the need for RC services.

Recovery Coaches are employed by a provider organization that can provide supervision, an organizational culture that supports fidelity to the model, meets credentialling requirements, and provides an environment that is conducive to the needs of an RC and the Enrollees they serve.

SERVICE COMPONENTS

1. Provide emotional and social support.
2. Peer Recovery Coaching is a non-clinical and non-medical service. The expectations and functions of a Peer Recovery Coach are different, but equally valuable to, those of clinical and medical staff.
3. Share recovery experience and use coaching and mentoring techniques to support an Enrollee's awareness and understanding that they possess their own recovery capital to help sustain their recovery.
4. Support Enrollees in making positive life changes and developing skills to facilitate their recovery.
5. Help Enrollees to discuss and try new strategies for developing recovery-supportive friendships, reconnecting, or improving family relationships and identifying and using recovery-community networks.
6. Assist Enrollees in creating personally meaningful links to treatment, peer recovery support services, and mutual aid, and support them in their efforts to build their capacity to move between and among these services and supports as needed.
7. Act in an open and transparent way as a role model and living example of a person in recovery.
8. When appropriate, use the peer relationship to assist with motivation and facilitate connections to primary and specialty medical, dental, and mental health services as well as social services, including applying for benefits and navigating other relevant systems, including criminal justice and child protection/child welfare.
9. Act as a recovery liaison and support the Enrollee in preparing for or accompanying Enrollee to meetings with, for example, probation officers, social workers, and child protection/child welfare workers.
10. Provide linguistically appropriate and culturally sensitive peer recovery supports that embrace the diversity of Enrollees' identities that include racial, ethnic, gender/gender identity, sex, sexual orientation, physical and intellectual challenges, and their chosen pathway to recovery.
11. Serve as an advocate for Enrollees and assisting Enrollees in learning self-advocacy skills
12. Act as a mentor, assisting the Enrollee's recovery process and supporting the Enrollee's goals and decisions; support the Enrollee in creating and enacting goals to work towards in recovery (this may include a wellness plan).
13. Provide RC services in a person-centered and strength-based manner.
14. The RC uses motivational interviewing and leverages evidenced based practices from trainings, to support the member's growth.
15. May provide temporary assistance with transportation to essential self-help, peer support and medical and behavioral health appointments while transitioning to community-based transportation resources.

16. Delivering services on a mobile basis to Enrollees in any setting that is safe for the Enrollee and staff. Examples of such a setting include, but are not limited to, an Enrollee's home, an inpatient or diversionary unit, a day program, a self-help meeting, or Recovery Support Center.
17. When working with pregnant and/or parenting Enrollees, in addition to the requirements listed above, an RC must:
    a) Use a peer mentoring framework, work collaboratively with the pregnant and/or parenting Enrollee to create and coordinate Plan of Safe Care (also called Family Support Plan) specifically designed to help the Enrollee identify needed services for recovery and parenting.
    b) Support Enrollee around perinatal health and support needs, housing needs, healthcare needs, income needs, mental health, and substance use treatment needs (including MAT), as identified in the Plan of Safe Care.
    c) Become familiar with local resources, such as home visiting services, lactation support services, parenting support groups, childcare programs, and other services designed to support parents and/or parents in recovery. Develop partnerships with local service providers, including local DCF and Early Intervention staff to facilitate engagement and self-advocacy on part of the Enrollee.
    d) Help Enrollee understand the DCF custody assessment process, and support Enrollee in advocating for custody as appropriate. Assist Enrollee in following through on a Plan of Safe Care, or a DCF Family Action Plan, if they have an open case.
18. To receive the case rate for RC services, the provider must document and be able to demonstrate that the RC has completed the following minimum activities with all Enrollees on the case:
    a) At least one in-person meeting at the onset of service delivery to develop initial goals with the Enrollee (this might include a wellness plan, as appropriate); and
    b) at least one connection with the Enrollee over a 21-day period. Connections can be made in person, over the phone, or by text provided that the Enrollee is engaged and responsive. These ongoing connections must support the peer relationship and support the Enrollee in working towards the goals with the RC.
    c) The provider must be able to demonstrate that they are fulfilling the requirements of the performance specification, including the minimum Enrollee interaction required for the daily case rate, plus sufficient time must be spent on case related work without Enrollee present to assist Enrollee in accomplishing goals (e.g., phone calls to providers, identifying materials). These activities are intended to support the work with the Enrollee but not replace actual connections between the RC and the Enrollee.

STAFFING REQUIREMENTS

1. RCs must be able to provide recovery support safely and effectively to others. They must be willing and able to share their path to recovery and their lived experience of recovery with Enrollees.
2. RCs must have at least a high school diploma or a GED, except in cases where a reasonable exception can be made

3. RCs must have successfully participated in trainings and/or coursework that is designed to prepare individuals to serve as a Recovery Coach. The training program must be approved by EOHHS.
4. RCs must receive direct supervision from a supervisor who has completed training and/or coursework that is designed to prepare supervisors to supervise recovery coaches. The supervisor training program must be approved by EOHHS.
5. RCs must have obtained or must be able to demonstrate that they are actively working to obtain, credentialing as a Certified Addiction Recovery Coach (CARC) through the Massachusetts Board of Substance Abuse Counselor Certification, or through another certification or credentialing process as specified by EOHHS.
    a) To be considered as working toward credentialing as a CARC, a Peer Recovery Coach must:
        i. have completed Peer Recovery Coach Academy trainings and the Ethical Considerations for Recovery Coaches training; and
        ii. must be in the process of completing supervision requirements and additional required trainings.
6. The RC is employed by a larger organization that provides behavioral health services and is licensed within the Commonwealth of Massachusetts.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider employing the RC maintains written affiliation agreements, which may include Qualified Service Organization Agreements (QSOA), Memorandum of Understanding (MOU), Business Associates Agreements (BAA) or linkage agreements, with local providers of these levels of care that refer a high volume of Enrollees to its program and/or to which the program refers a high volume of Enrollees. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
2. Organizations that employ RCs are expected to have affiliation agreements with a wide variety of organizations, including behavioral health, medical, and non-medical service settings including:
    a) Addiction Services
        i. Non-24 Hour Addiction Treatment
            - Structured Outpatient Addiction Programs
            - Substance Use Disorder Outpatient Clinics
            - Opioid Treatment Programs
        ii. 24 Hour Addiction Treatment
            - Acute Treatment Services (Level 3.7)
            - Clinical Stabilization Services (Level 3.5)
            - Transitional Support Services (Level 3.1)
            - Residential Rehabilitation Services (Level 3.1)
    b) Other Behavioral Health
        i. Behavioral Health Community Partners

    ii. Emergency Service Programs (ESP)
    iii. Licensed Mental Health Centers
    iv. Partial Hospitalization Programs

c) Medical Settings
    i. Emergency Departments
    ii. Primary Care Practices
    iii. Licensed Mental Health Centers
    iv. Hospital Settings
    v. OB/GYN Practices
    vi. Community Health Centers

d) Other Settings
    i. Criminal Justice Programs
    ii. Specialty Drug Courts
    iii. Faith Based Organizations
    iv. Recovery Support Centers
    v. Supportive/Sober Housing

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The Enrollee defines and directs the structure and content of his or her own wellness and recovery. A wellness plan may be a structure that is used to support the RC in their wellness and recovery. Goals and the plan for the Enrollee's journey in recovery is made in a collaborative and supportive manner with the RC. With the Enrollee's consent a copy of the wellness plan is part of the Enrollee's record. Wellness plans do not need to follow a standard template but must meet the individual needs of the Enrollee.
2. The RC must document the required activities for the case rate, including the initial in person visits and the ongoing weekly contacts.
3. The initial goals and plan, along with progress notes recorded through the stages of change framework, will be used for documentation for clinical review and medical necessity.

Discharge Planning and Documentation

None

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.