Engaging Patients Meaningfully in Equity Initiatives

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Objectives

- Review definition, statistics, and causes of maternal mortality
- Review strategies promoting maternal health equity
  - Health Equity and Reflective Care (Her-Care)
  - Patient and family engagement initiative
  - Peer to peer support program
    - Certified peer specialists

Goals of Break-out Session

BRAINSTORMING

MUTUAL INFORMATION SHARING

Maternal Mortality

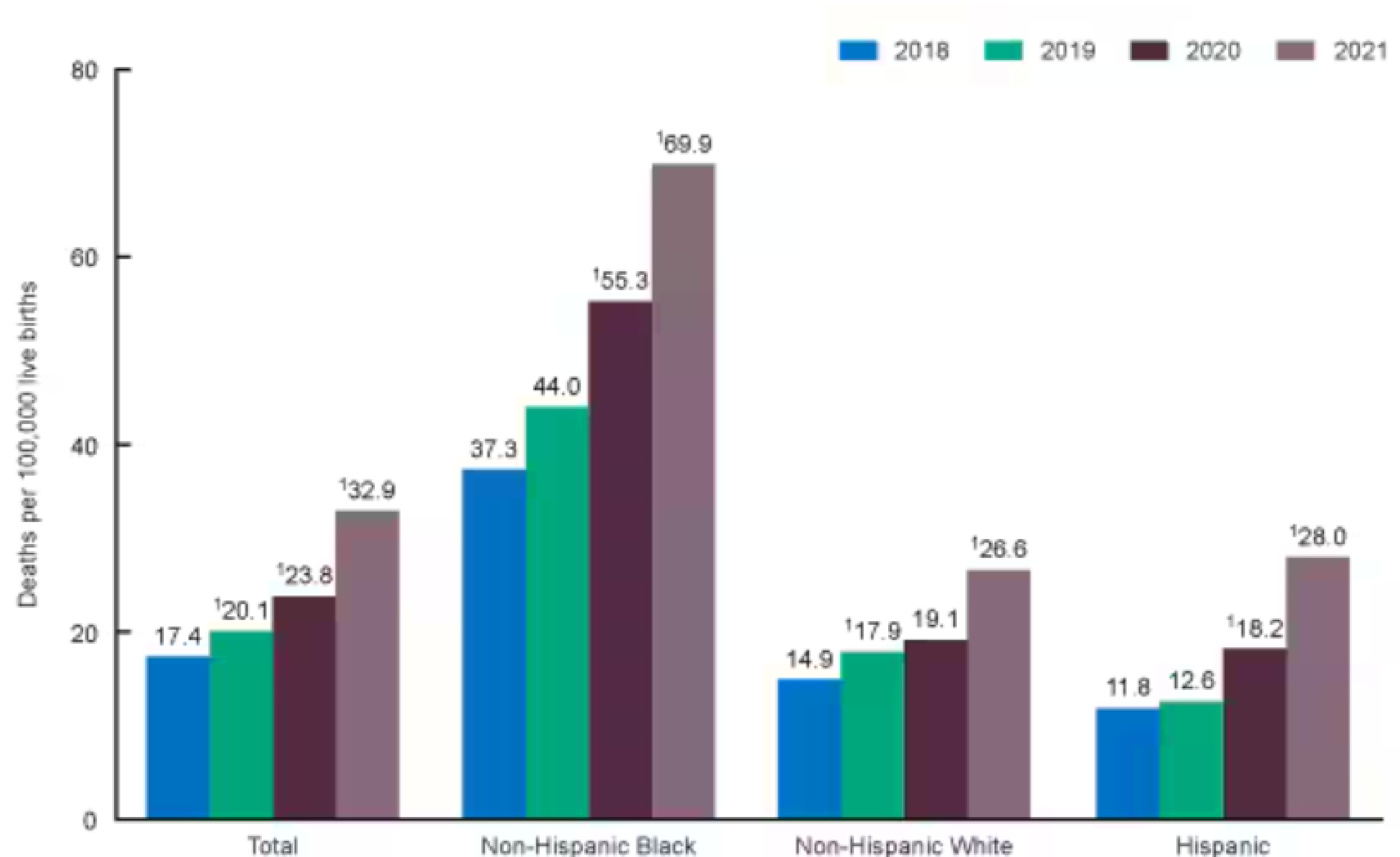
- Maternal Death
  - Annual number of individuals' deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified time period.
- Maternal Mortality Rate
  - The maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period
- US maternal mortality ratios increased from 17.4 in 2018 to 32.9 per 100,000 live births in 2021
  - GA→ 33.9 per 100,000 live births (2018-2021)
- Largely preventable, and outcomes can be improved through quality initiatives

(CDC, 2022; WHO, 2020)

Maternal Mortality Statistics

(CDC, 2022)

Figure 1. Maternal mortality rates, by race and Hispanic origin: United States, 2018–2021



Causes of Maternal Mortality

- Leading underlying causes of pregnancy-related death include:
  - Mental health conditions (including deaths by suicide and overdose/poisoning related to substance use disorder) (23%)
  - Excessive bleeding (hemorrhage) (14%)
  - Cardiac and coronary conditions (relating to the heart) (13%)
  - Infection (9%)
  - Thrombotic embolism (a type of blood clot) (9%)
  - Cardiomyopathy (a disease of the heart muscle) (9%)
  - Hypertensive disorders of pregnancy (relating to high blood pressure) (7%)

(CDC, 2022)

Preventing Maternal Deaths

Maternal Health Equity

Access to care

Hypertensive disorders

Cardiovascular conditions

Implicit bias

Hemorrhage

Maternal mental health

(OBHG,2024)

Foundation of Health Equity (CDC Course)

Domain 1: Embrace equity as the foundation of organizational commitments, policies, and practices

Domain 2. Establish and maintain infrastructure to advance equity

Domain 3. Communicate effectively to advance equity

Domain 4. Engage communities and mobilize partners to enable effective and sustainable organizational efforts

Domain 5. Advance health equity in the context of structural and social determinants of health

Domain 6. Embody anti-racism and anti-oppression in all aspects of the organization and its interventions

https://www.cdc.gov/healthequity/training/index.html

Strategies Promoting Maternal Health Equity

Equity-Promoting QI Strategy	QI Strategy and Tactic Category*
1. Communicate maternal equity as a priority through leadership[5,23,31–34]	A, B, C, D, S
Ingrain equity as a strategic goal	
Acknowledge the effect of racism	
Invest resources and support	
Foster multidisciplinary collaboration	
Develop data systems to capture disparities	
Establish a departmental health equity committee	
Establish a culture of equity†	
2. Leverage data and enhance surveillance[4,5,21–23,31–34,37,39–46,48–50]	A, C, D, E, S
Stratify metrics by REaL, SOGIE, SDOH, and geography	
Identify root cause and magnitude of disparities	
Self-report of demographic identifiers	
Create equity dashboards	
Use of MMRC findings to inform QI project selection	
Implement standardized screening tools	
Include patient-reported experience measures	
Incorporate community indicators into the maternal mortality review process	
3. Engage and collaborate with strategic partners[4,5,23,32,39,40,42,45–48]	A, B, C, D, S
Include broad stakeholders	
Communicate efforts widely	
Engage partners to build capacity	
Include community and partner knowledge and expertise	
4. Collaborate with and listen to patients and members of the community[5,31,34,39–43,45–47,51]	A, C, D, E, S
Incorporate community experience in project selection	
Engage communities in PQC governance and project development	
Invite community members to hospital equity committees	
5. Educate clinicians[4,5,21–23,31–34,39,42,45,47,49–51]	A, B, C, D, E, S
Provide clinical updates	
Host trainings on QI tools and strategies	
Provide education on the effect of racism and bias on maternal care and health outcomes	
Incorporate health equity rounds	
6. Collaborate to implement best practices[4,5,21–23,31,34,39,41,42,44,47–49]	A, C, D, E, S
Adopt maternal safety bundles	
Standardize maternal care for all populations	
Engage in collaborative learning and implementation	
Openly share and use rapid, real-time data to assess progress	
Implement disparities-sensitive measures	

QI, quality improvement; REaL, race, ethnicity, and language; SOGIE, sexual orientation, gender identify, and experience; SDOH, social determinants of health; MMRC, maternal mortality review committee; PQC, perinatal quality collaborative.

* A=Accountability, B=Buy-in (incentives or disincentives), C=Collaboration and Communication, D=Data, E=Education, S=Structure Changes (refer to Table 1).[25]

† Systems with a culture of equity value and actively work toward ensuring that everyone gets the care and support they need to achieve their fullest potential for health.

Discussion

- Are strategies 1, 3, and 4 reflected in your respective institutions? If so, how?
- How could strategy 1 be incorporated in your institution?
- How could strategy 3 be incorporated in your institution?
- How could strategy 4 be incorporated in your institution?

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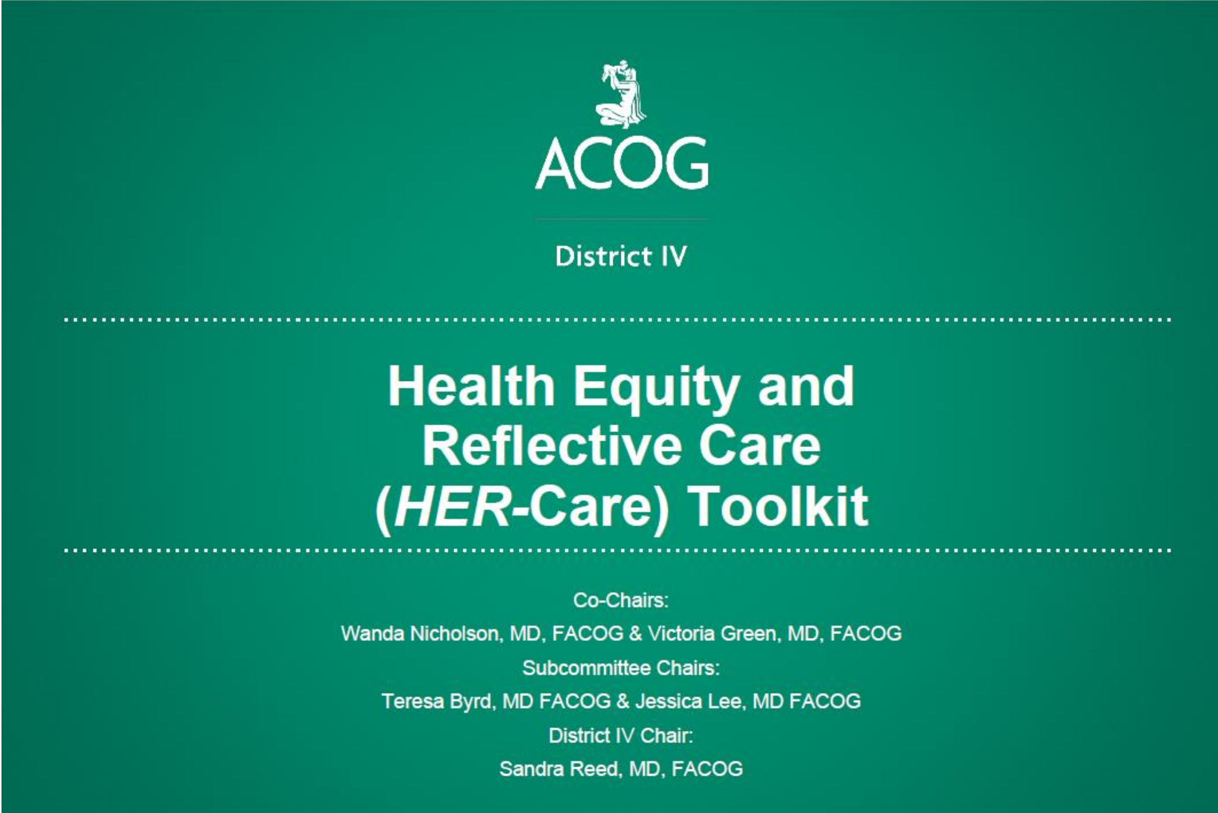
Implicit Bias in Maternal Care

- How does implicit bias affect health care?
  - https://www.youtube.com/watch?v=ze7Fff2YKfM
- Negative stereotype traits in healthcare
  - https://www.youtube.com/watch?v=M1vM_ywbUfc
- Implicit bias in maternal health?
- Negative stereotypes in maternal health?
- Is implicit bias being addressed in your Institution?
  - If so, how?
  - If not, why?

Addressing Implicit Bias: HER-Care Toolkit



Health Equity & Reflective Care (HERCa

1 Individual training

- Implicit bias awareness
- Motivation to change
- Concrete strategies to change behavior

We recommend **individual trainings** initially focus primarily on bias awareness and motivation to change behavior. Later training change behavior. Participation in at least one individual training should be required **annually**.

2 Institutional/group/team training

- Health equity M&M / rounds
- Implicit bias drill enhancement
- RCA supplemental questions

Institutional/group/team training should be employed in all departments and specialties with emphasis on modeling appropriate with standards of care, etc.). Institutional/group/team trainings **should be incorporated into routine activities** (conferences, drills training should become a part of daily activities.

3 Change sustaining resources

- Implicit Bias "Friction" Acronym Posters
- Respectful Care Videos (Social media)
- Respectful Care Pledge

Change sustaining resources should be **used as adjuncts** to the individual and group trainings to reinforce and help sustain pos hanging the "friction" acronym posters in patient rooms and outside on the door; have the team read the respectful care pledge bef respectful care videos on social media platforms.

Implicit Bias Training Application

IMPLICIT BIAS DRILL ENHANCEMENT

- Include a case scenario in your unit/team drill (2 cases included: hypertension, pain/postpartum hemorrhage)
- Add details that commonly trigger implicit biases (race/ethnicity, female gender, age, substance abuse, obesity, etc.)
  - For example: *A 26-year old Black G8P6016 @ 32 1/7 weeks presents with complaints of abdominal pain. You notice only two contractions on the monitor. Her first blood pressure is 189/99, and on repeat 45 minutes later it is 195/101. Category I FHT. She has a history of drug abuse. She is also upset and arguing on the phone with the father of her baby…*
  - Ask participants what kind of assumptions could be made about the patient.
- Discuss how implicit biases can interfere with adherence to standards of care and protocols
- Highlight how and why different groups will respond or react differently and how behaviors can be inappropriately interpreted
- Highlight how and why regardless of the patient's history (*drug abuse*) or other factors (*arguing with father of baby*) the patient is still at risk of significant morbidity (*stroke, abruption, etc.*)
- Emphasize why adherence to standards of care and protocols leads to better outcomes

…

Available Resources

GaPQC Website

- Full HER-Care Toolkit
- SBAR Communication Tools
- Culturally and Linguistically Appropriate Services (CLAS)

Personnel and/or technical support

Situation, Background, Assessment, Recommendations (SBAR)

SBAR is a technique that is typically used to frame conversations between health care providers regarding a patient's condition and clinical status. SBAR in this circumstance is adapted to promote respectful and inclusive patient communication and care. It is important to recognize that each patient, couple, and family are unique. These sample SBARs are not all-inclusive

AWHONN SBAR for Respectful Patient Care for Black Women (pdf)

Download

AWHONN SBAR for Respectful Maternity Care (pdf)

Download

AWHONN SBAR for Women, Pregnant, and Postpartum People with Limited English Proficiency (LEP) (pdf)

Download

AWHONN SBAR Respectful Maternity Care for Individuals with Substance Use Disorder (SUD) (pdf)

Download

AWHONN SBAR Respectful Patient Care for Individuals Who Identify as LGBTQIA+ Same-Sex Couple Who Bot (pdf)

Download

AWHONN SBAR for Individuals Considering Adoption (pdf)

Download

AWHONN SBAR for Native American/American Indian/Alaska Native/Indigenous Patients (pdf)

Download

AWHONN SBAR for Deaf/DeafBlind*/DeafDisabled/Late-Deafened/Hard of Hearing (DDBDDLDHH) Community (pdf)

Download

SBAR FOR INCLUSIVE AND EQUITABLE PATIENT CARE

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SBAR for Women, Pregnant, and Postpartum People with Limited English Proficiency (LEP)	
Situation	A care provider enters a clinic room to meet and establish a relationship with their patient in a maternal-fetal medicine office. She presents for genetic testing for a concerning finding on 20-week ultrasound. The patient is a 21-year-old G1 P0 woman who self-identifies as Hispanic and female. Her primary language is Spanish, and she states that she understands minimal English. She also has a history of Type 2 diabetes. The patient is accompanied by her boyfriend and mother. She appears to be anxious and frightened.
Background	What are some challenges patients and their families with limited English proficiency (LEP) may face when receiving health care? • Federal and state legislation and regulatory bodies such as the Joint Commission require translation services to ensure the needs of individuals with LEP are met in health care settings that accept federal funding (Taira et al., 2019). • According to the United States (U.S.) Census Bureau, anyone above the age of five who reported speaking English less than "very well" is classified as having LEP. There are approximately 25.1 million individuals inhabiting the U.S. that are considered to have LEP (Zong, 2015). • Attitudes, beliefs, and the quality of interpretation resources available to the LEP population may exacerbate communication barriers and are associated with increased frequency of medical errors, readmission rates, length of stay, and isolation felt by the patient and their families (Howell et al., 2018). • Health care interactions can be both positive and negative; however, several factors can influence the provision of and access to Respectful Maternity Care (RMC), including the level of provider awareness and acceptance of patients' cultural differences, life experiences, and ability to communicate effectively (de Peralta et al., 2019). • Disparities in health care are exacerbated when English is not the primary language of the patient (Howell et al., 2018). • Cultural awareness includes committing to cross-cultural care while being able to understand our own biases and prejudices towards people who are different (Shorey & Downe, 2021). • Care providers should utilize culturally responsive interventions to help mitigate structural barriers that diverse communities may experience when accessing health care services (Meléndez Guevara et al., 2020).
Assessment	Based on what I know about my patient, which assessments are a top priority in establishing a positive relationship with this patient and their family? Self-assessment: • I will first engage in a self-assessment to identify and recognize any personal bias that I may have. • I will reflect on how language barriers add another layer of vulnerability and can impact disparities in care and outcomes. • I will reflect on how language and culture are linked. I may need to do additional research to increase my own knowledge about other practices, languages, and resource availability. • I will understand personal and institutional barriers to delivering care and how to eliminate discrimination and bias in people with LEP. Patient Assessment: • I will work to build trust and rapport with this patient and their family by engaging with medically approved interpretation services. • I will ask which translation interpretation modality (in person, virtual) the patient and family members prefer. • I will ask if there are any customs that they plan to bring forth in their birthing experience and be respectful of those customs. • I will ask about this patient's or their partner's previous obstetrical or medical experience/ history, listen, and validate their concerns with compassion and respect using a trauma-informed approach.
Recommendations	What actions can be taken to help this patient and their partner feel heard and understood? • I will include this patient and their partner in all care decisions from admission through discharge. • I will establish a communication modality that the patient prefers and continue to use it throughout their hospital stay. I will ensure the patient is fully informed and demonstrates a clear understanding before consent is signed. • I will validate their care needs and concerns, ensuring the interprofessional team understands their preferences to deliver individualized care and support. • I will act promptly on the signs and symptoms they express to prevent, minimize, or eliminate harm. • I will avoid assumptions about cultural practices and English proficiency. • If there is a mistake in my communications, I will apologize and adapt my communication strategies as needed.

ACTIONS

- After hearing and documenting this patient's previous experiences, I will reflect on the experience to determine what I can do to decrease discrimination and bias and ensure that they receive respectful, informed, and compassionate care.
- I will strive to identify and address clinic, unit, hospital, and systems issues in the facility where I work, specifically those that impact the ability to communicate effectively with people with LEP.

Patient and Family Engagement

Engaging Patients and Families in Care Delivery

FAMILY VOICES®

RULES OF FAMILY ENGAGEMENT

Be Committed
Create a family engagement policy to set a standard for engaging families as partners on all policy-making groups.

Document Impact
Work with families to report how their input & ideas were used to improve existing policies or to create new ones.

Be Transparent
Ask families about the information & supports they need to partner, participate & contribute.

Be Representative
Engage families who represent the children & families the organization serves.

Learn How to Plan, Assess, & Improve Family Engagement
Download the Family Voices Family Engagement Tools

WWW.FAMILYVOICES.ORG/FESAT

Framework for Family Engagement in Systems Change

Domain 1: Commitment
- Family Engagement is a core value.

Domain 2: Transparency
- Access is provided to relevant knowledge and supports.

Domain 3: Representation
- Engaged families reflect the diversity of the community served (race, ethnicity culture, language, and geography.

Domain 4: Impact
- The initiative identifies what has changed and what the organization is doing differently because families are involved.

HOW TO "COMMIT" TO MEANINGFUL FAMILY ENGAGEMENT IN SYSTEMS

COMMITMENT

Organizations must always engage families they serve in decision-making groups that are working to improve or create the policies, programs, and services they provide for children, youth, and families.

CREATE A POLICY

- A family engagement policy sets a standard for engaging families in all systems-level initiatives & ensures that policies are family-centered & equitable.
- Provide compensation to recognize families time & expertise, reduce barriers to participation & ensure equitable representation.

IDENTIFY CHAMPIONS

- Designate one or more staff members to lead family engagement efforts.
- Support staff development to enhance understanding of the value of family partnership.

LEARN MORE

Visit the Assessing Family Engagement webpage and download the **Family Engagement in Systems Toolkit**, a collection of strategies and resources to help improve family engagement in systems-level initiatives.

FAMILY VOICES® **www.familyvoices.org**

HOW TO ENSURE TRANSPARENCY IN FAMILY ENGAGEMENT IN SYSTEMS

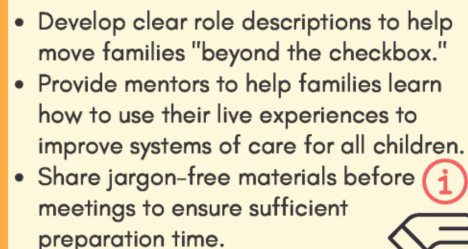
TRANSPARENCY

Organizations must clearly document and communicate how they:

- Identify issues faced by the children, youth, and families it serves.
- Provide the information & supports families & staff need to partner, participate, & contribute to their maximum potential.

IDENTIFY THE ISSUES

- Partner with family-led or community-based organizations to learn what they are hearing from families.
- Reach families directly.
- Co-create needs assessments, surveys, conduct focus groups, other feedback mechanisms.
- Use data from a variety of sources.



PROVIDE INFORMATION & SUPPORT

- Develop clear role descriptions to help move families "beyond the checkbox."
- Provide mentors to help families learn how to use their live experiences to improve systems of care for all children.
- Share jargon-free materials before meetings to ensure sufficient preparation time.

LEARN MORE

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HOW TO DEMONSTRATE THE IMPACT OF FAMILY ENGAGEMENT IN SYSTEMS

IMPACT

Organizations must report on how and where families' input and ideas were used to improve existing, or create new policies, programs, and services to benefit all children, youth, and families.

LISTEN

Ensure families feel welcome and have opportunities to provide input.

- Families know what works well and what doesn't work about systems of care. Listen to their lived experience.
- Work together to identify areas for improvement.
- Work together to identify solutions.

IDENTIFY CHANGES

- Recognize what the organization is doing differently because families were engaged in the initiative.
- Document families' contributions to the work.
- Work together to create an action plan to improve family engagement in systems-level initiatives.

LEARN MORE

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FAMILY VOICES® **www.familyvoices.org**

HOW TO ENSURE EQUITABLE REPRESENTATION OF FAMILIES IN SYSTEMS

REPRESENTATION

Engaged families must represent the diversity of the children, youth, families, and other individuals served by the organization.

KNOW THE POPULATION

Engage families who reflect the diversity of those served by the organization or the specific systems-level initiatives.

- Use internal or external data the demographics of those served.
- Connect with a family-led or community-based organization to help recruit & support family partners.

OFFER TRAINING

Provide skill-building opportunities for family partners and staff. This might include:

- Workshops about family-professional partner and family engagement.
- Implicit bias training so all participants are aware of the assumptions they may make about others.

LEARN MORE

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FAMILY VOICES® **www.familyvoices.org**

Available Resources

Culturally and Linguistically Appropriate Services (CLAS)

Situation, Background, Assessment, Recommendations (SBAR)

Family Engagement Assessment Toolkit

Activity

Guide the Design of an Initiative to Ensure Family Engagement

Child- and family-serving organizations can use this **Family Engagement Checklist** to identify the supports the organization already provides as well as supports to implement to plan and ensure meaningful family engagement in systems-level initiatives.

Family Engagement Checklist

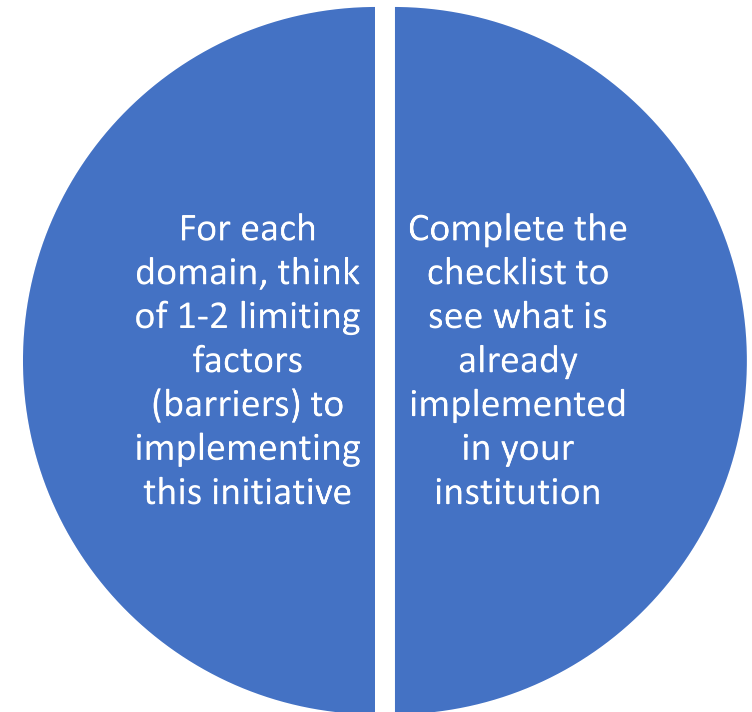
Domain 1: Commitment	Yes	No	Some what	Don't know
The organization uses written policy that requires family engagement in systems-level initiatives.	☐	☐	☐	☐
The organization has one or more champions of family engagement.	☐	☐	☐	☐
The organization acknowledges the contributions family leaders make to systems-level initiatives.	☐	☐	☐	☐
The organization's budget includes funding for family leaders' time and/or other costs they incur (for example, travel, child care).	☐	☐	☐	☐
The organization provides adequate time for staff to implement changes that result from family engagement in systems-levels initiatives (for example, educating staff about new policies).	☐	☐	☐	☐

Domain 2: Transparency	Yes	No	Some what	Don't know
The organization conducts activities to understand the issues faced by the children and families they serve (for example, used data or conducted a focus group).	☐	☐	☐	☐
The organization ensures all staff and families have a clear understanding of the initiative they will work on together.	☐	☐	☐	☐
The organization provides the supports families and staff need to understand their partnership role (for example mentors/coaching).	☐	☐	☐	☐
The organization ensures all participants have the supports they need to participate in meetings (for example, physical access, interpreters, time away from other work responsibilities).	☐	☐	☐	☐
The organization ensures all participants have the information they need to participate in meetings.	☐	☐	☐	☐

Domain 3: Representation	Yes	No	Some what	Don't know
Family leaders are representative of the races and ethnicities of the populations served by the initiative.	☐	☐	☐	☐
Family leaders are representative of the cultures of the populations served by the initiative.	☐	☐	☐	☐
Family leaders are representative of the languages spoken by the populations served by the initiative.	☐	☐	☐	☐
Family leaders are representative of geographic areas in which populations served by the initiative live.	☐	☐	☐	☐

NOTE: If one or more of the four demographic characteristics in Domain 3: Representation, do not match your priorities for the populations served by the initiative you are assessing, you can replace them with criteria that do match your priorities. For example, your organization may be looking for family leaders of certain ages, disabilities, gender, etc.

Domain 4: Impact	Yes	No	Some what	Don't know
Organization staff listen to family leaders' ideas.	☐	☐	☐	☐
Organization staff engage family leaders in choosing goals for the initiative.	☐	☐	☐	☐
Organization staff work together with family leaders to implement the initiative.	☐	☐	☐	☐
Organization staff work together with family leaders to evaluate the initiative.	☐	☐	☐	☐
Organization staff use family leaders' input to improve the initiative.	☐	☐	☐	☐
Organization staff can explain how family leaders contribute to the initiative.	☐	☐	☐	☐



Perinatal Mental Health – Maternal Peer to Peer Support

Slides adapted from ZOMA Foundation

Maternal Peer Support

Approximately 1 in 5 women struggle with maternal mental health disorders such as anxiety and depression, yet most go untreated.

Scarcity of qualified and financially accessible mental health providers.

- HRSA, 2020→ over 5700 mental health professional shortage areas in the U.S.

In response to provider shortage and growing need →recent interest in utilizing certified peer specialists for peer-to-peer support

Peer specialists found to be effective in reducing anxiety and depression in pregnant and postpartum women

What is Peer Support

Mental Health America

Peer support is an evidence-based practice that:

- Improves outcomes and quality of life
- Reduces hospitalizations and cost of services for consumers

Through its focus on empowerment, mutuality, and the whole person, it has the power to fundamentally change how we approach and engage people around their mental health and wellbeing.

SAMHSA

Peer support encompasses a range of activities and interactions between people who have shared similar experiences of being diagnosed with mental health conditions.

This mutuality – often called "peerness" – between a peer worker and person using services promotes connection and inspires hope.

Is Peer Support Recognized by the Federal Government?

YES!

SAMHSA, CMS, and HRSA to name a few

The Centers for Medicaid and Medicare Services (CMS):

Has recognized the efficacy of using peer support in mental health since 2007. SAMHSA also recognizes Peer Support.

Defines Peer Support Services As:

"An evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness."

Recognizes that the experiences of peer support providers, as consumers of mental health services, can be an important component in a State's delivery of effective treatment

Certified Peer Support Works

Peer support care models alleviate the burden of mental health both on individuals and the U.S. healthcare system through a variety of mechanisms:

- As certified peer specialists typically are of the communities they work within, they decrease stigma, enhance cultural competency in care, and increase community access.
- They provide cost-effective services and support by preventing hospitalizations and offering lower treatment costs.
- Peer support providers can help overcome Black, Indigenous, and People of Color (BIPOC) community mistrust of clinical settings and providers due to traumas of historical and present individual,

institutional and systemic racism.

- Peer Delivered Self Help
  - Usually offered as part of a group of voluntary small group structures for mutual aid in the accomplishment of a specific purpose
  - informally offered on a voluntary basis to another peer to mutually assist each other to satisfy a common need/goal
- Peer run services
  - Peer-run services are those that are planned, administered and led by peers. These service programs may be legally independent entities, but often these service programs are embedded within a larger non-peer organization.
- Peer Partnerships
  - These are organizations where fiduciary responsibility lies with non-peers and administrative and operational responsibilities is mutually shared by both peers and non-peers, but primary control is with peers.
- Peers in recovery as employees
  - Individuals who are hired into designated peer positions or traditional mental health positions who must publicly self-identify as a peer and have been or are a service user themselves for their own mental health challenge

- Augment Mental Health Providers Shortages & MMH Super Shortages
- Decrease Stigma
- Enhance Cultural Competency in Care
- Increase Access in Community
- Cost Effective Expansion of Services and Supports
- Provide Meaningful Career Pathways for Mothers

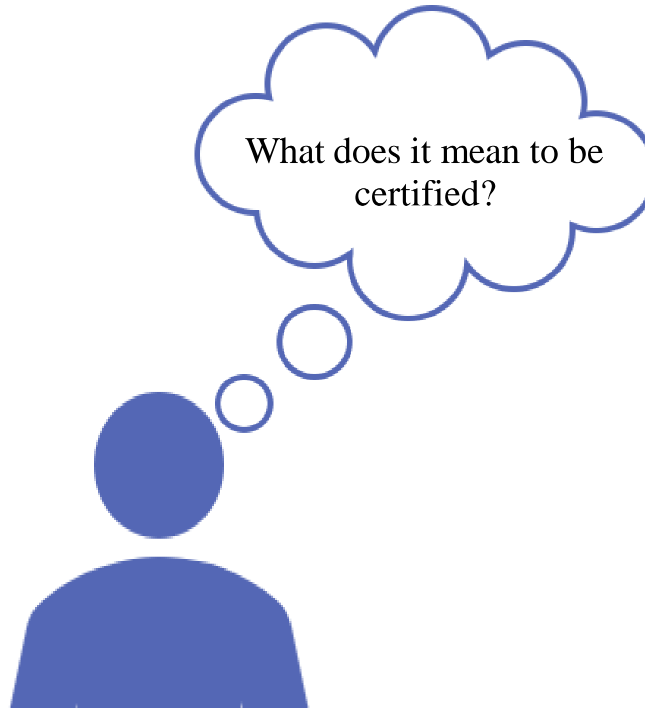
Core Competencies for Peers
Engages peers in collaborative and caring relationships
Provides support
Shares lived experiences of recovery
Personalizes peer support
Supports recovery planning
Links to resources, services, and supports
Provides information about skills related to health, wellness, and recovery
Helps peers to manage crises
Values communication
Supports collaboration and teamwork
Promotes leadership and advocacy
Promotes growth and development

Peers Service Activity Domains
Promote hope
Serve as role model
Share recovery story
Help reduce isolation
Do recovery planning
Have flexible time and meeting places
Engage clients in treatment
Increase client's participation in own illness management
Help link clients to community resources
Serve as liaison between staff and clients
Increase access to services
Run recovery groups
Focus on strengths
Provide empathy
Promote empowerment
Develop trusting relationship
Teach coping skills
Teach problem solving
Help their team focus on recover

What is a "Certified" Peer Specialist?

"Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function."

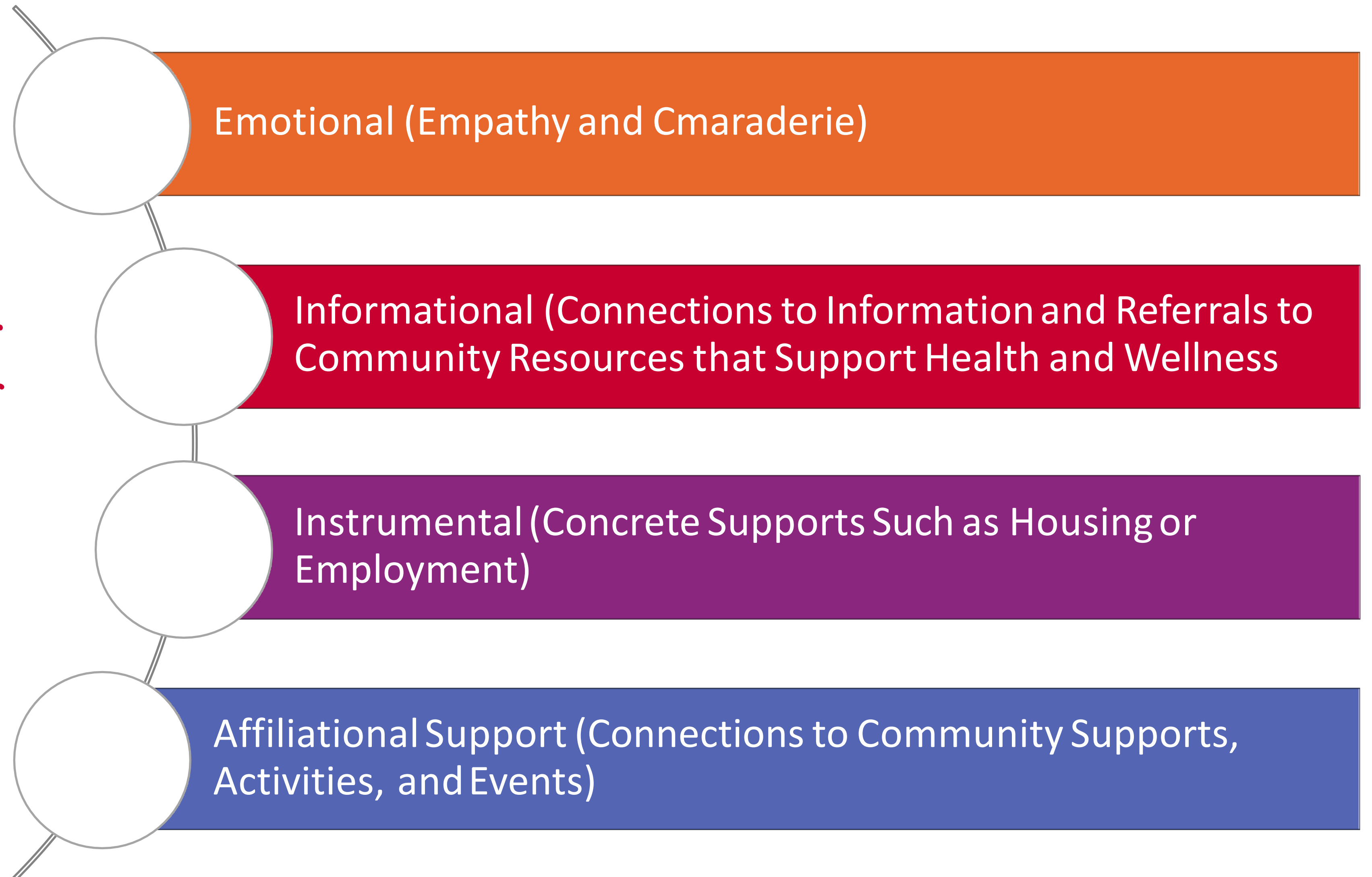
CMS



- Those who are "certified" sit for a test through an agency identified by the state.
- The testing process ensures the peer retained key knowledge provided through training, and allows peers to be issued a professional credential.
- 49 states except CO has a peer specialist certification process.
- However, those processes and requirements look different across states as well as the types of mental health issues peers are allowed to engage in.

What do Peer Specialists Do?

Peer Workers Offer Different Types of Support, Including:

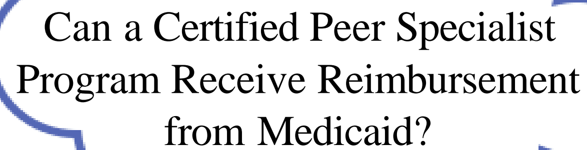


Training

- Several maternal mental health peer training programs.
  - Though these programs are helpful, they do not qualify as required training to become a state-certified peer specialist.
- To be recognized as a peer support specialist in the state → determine what type of training is required in the state or county
- Peer Support Specialist State Certification + Maternal Mental Health Add-On Training

	Is there a state-endorsed certification process?	Is there a state-wide certification test?	Training providers (vendors) and their contact information.	What are the educational requirements to apply for a peer specialist training program?	What are the personal requirements to apply for a peer specialist training program?	What are the professional requirements needed to apply for a peer specialist training program?
Georgia	Yes	Yes, following successful complete of training, participants must pass the Georgia Certified Peer Specialist Exam. Exams are taken approximately 2 to 4 weeks following the training with 5 exam periods per year. Exams are administered in person in Tucker,	Georgia Certified Peer Specialist Project Georgia Mental Health Consumer Network 1990 Lakeside Parkway, Suite 100 Tucker, Georgia 30084 info@gmhcn.org Tel 404-687-9487	High school diploma/GED Strong reading, comprehension, and written communication skills should be shown by answers on the application. A disclaimer on the application reads, in part: ""This is not about right & wrong answers. It is a brief examination to assess your reading & writing skills as well as your understanding of the requirements to become a Certified Peer Specialist in the State of Georgia and your lived experience with recovery."	Candidates must be willing to identify as a person living with a mental health condition and be willing to use their lived recovery experience to support others in their recovery. Must be well grounded in recovery exampled by atleast one year working toward wellness and recovery. Specific requirements for a CPS-AD, is 2 years of abstinence from alcohol and drugs.	Applicants have demonstrated experience with leadership, advocacy, or governance.

Program Reimbursements?



Most states reimburse for certified peer specialists billed time through their Medicaid programs.

At least 36 states offer providers the opportunity to bill Medicaid for mental health peer support services. They can do so through mechanisms such as a state plan amendment, the rehabilitation services option or a Medicaid waiver.

A few states also fund grant programs or other alternative financing to support peer specialists.

NCSL

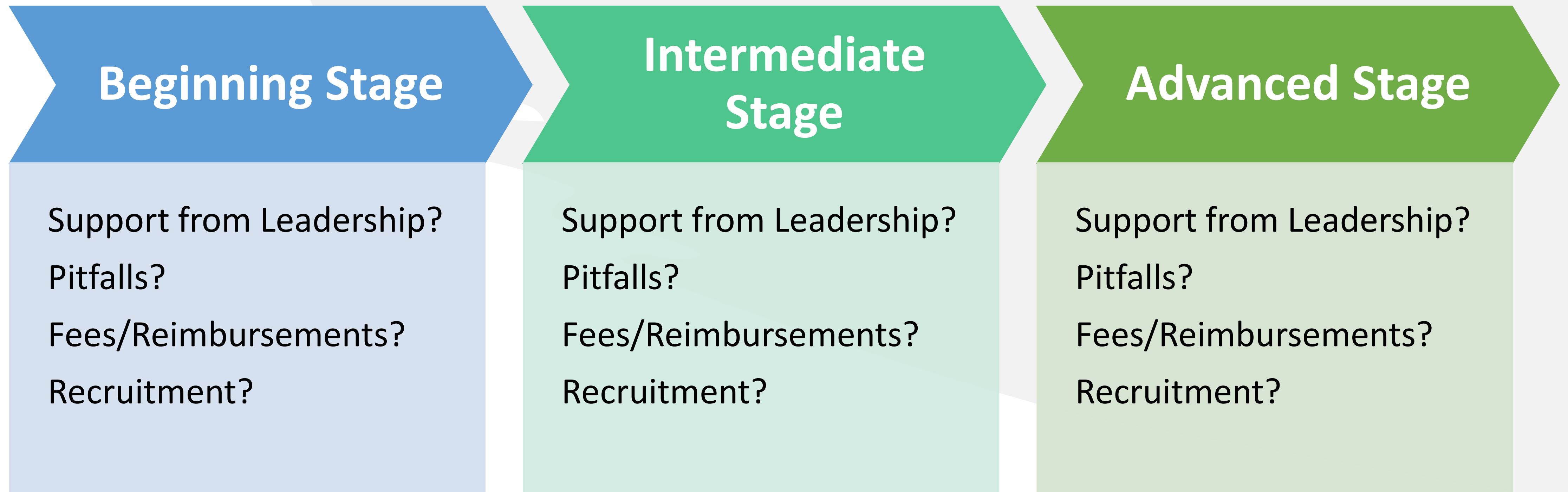
	What are the personal/professional requirements for certification, if they differ from attending the training?	What are the training requirements to become a Certified Peer Specialist?	What is the average cost for CPS training?	What is the cost of the certification test?	Who is responsible for paying for training? (List all)
Georgia	N/A	It is a 2 week training for a total of 9 days (Monday through Friday of week one and Monday through Thursday of week two), usually from 8:30am to 4:30pm.	$85 registration fee that covers cost of training materials, due by the first day of training.	N/A	Individual

	Are Certified Peer Specialists services Medicaid reimbursable?	Aside from any fees for the training or state-wide certification test, are there other certification fees/costs?	Does the certification test need to be taken regularly to maintain certification?	How are peer support services paid for by the state? What specific Medicaid waivers are used, if any?
Georgia	Yes	N/A	N/A	Adult peer support specialists are paid for by a Rehabilitative Services State Plan Option. YPS are paid for through 1915(c) Home and Community Based Services Waiver.

Available Resources

- Reimbursement
  - NIATx Third-Party Billing Guide
  - State Medicaid Reimbursement for Peer Support
- Program Implementation
  - Defining Peer Support Worker Job Roles and Tasks
  - Using Certified Peer Specialists to Prevent and Combat MMH Disorders
  - Introducing Peer Support into Your Organization: Expanding Peer Support in Behavioral Health
  - Supervising Peer Workers: A Toolkit for Implementing and Supporting Successful Peer Staff Roles in Mainstream Mental Health and Substance Use/Addiction Organizations
  - PEER SUPPORT Toolkit
  - Culturally and Linguistically Appropriate Services (CLAS)
  - Situation, Background, Assessment, Recommendations (SBAR)
- Peer Support Specialist State Certification
  - Georgia Peer Support Institute
- Maternal Mental Health (MMH) Add-On Training

Potential Barriers and Solutions to Peer Support Program



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