# 969 COLLABORATING WITH PEERS AND FAMILIES

EFFECTIVE DATE: (Month XX, 2024)
REFERENCES: AMPM 100; AMPM 964

## PURPOSE

This policy sets forth guidance for AdSSs when collaborating with Peers and Family members of Division Members.

## DEFINITIONS

1. "Adult's Integrated System of Care" or "ASOC" means for adult Members, the AdSS shall adhere to Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, that were developed to promote recovery in the adult behavioral health system; system development efforts, programs, service provision, and stakeholder collaboration shall be guided by these nine principles.
2. "Child and Family Team" or "CFT" means a defined group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker (HCDM), a behavioral health representative, and any individuals important in the child's life who are identified and invited to participate by the

child and family. This may include teachers, extended Family Members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Department of Child Safety (DCS) or the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). The size, scope, and intensity of involvement of the team Members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan and can therefore expand and contract as necessary to be successful on behalf of the child.

3. "Children's Integrated System of Care" or "CSOS"means for child Members, the AdSS shall ensure delivery of services in conformance with Arizona Vision-12 Principles for Children Behavioral Health Service Delivery and shall abide by AHCCCS Appointment Standards specified in ACOM Policy 417.

4. "Credentialed Family Support Partner" or "CFSP" means an individual who is qualified under this policy and has passed an AHCCCS/DCAIR, OIFA approved CFSP Training Program to deliver Credentialed Family Support Services.
5. "Family Member" means:
    a. For the adult system, an individual who has lived experience as a primary natural support for an adult with emotional, behavioral health and/or Substance Use Disorders (SUD); and
    b. For the children's system, a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health or a SUD.
6. "Family Run Organization" or "FRO" means Family-Operated Services that are:
    a. Independent and autonomous - Governed by a board of directors of which 51% or more are Family Members who:
        i. Have or had primary responsibility for the raising of a child, youth, adolescent or young adult with an

emotional, behavioral, mental health or substance use need;

ii. Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance use need; or

iii. An adult who had lived experience of being a child with emotional, behavioral, mental health or substance use needs.

b. Employs CFSP whose primary responsibility is to provide parent/family support.

7. "Family Support Service" means home care training with Family Member(s) directed toward restoration, enhancement, or maintenance of the family functions to increase the family's ability to effectively interact and care for the individual in the home and community.

8. "Health Care Delivery System" means the structure and organization of covered services and Benefit Packages available to Contractor's Members.

9. "Integrated System of Care" or "ISOC" means integrated physical and behavioral health care within the AHCCCS Health Care Delivery System focused on ensuring appropriate, adequate, and timely services for all persons across the lifespan, with a primary focus on improving quality of life throughout all system intersections and service interactions that individuals may encounter.

10. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

11. "Peer" means an individual with lived experience of mental health conditions, substance use, and/or other traumas resulting in emotional distress and significant life disruption, for which they have sought help or care, and has an experience of recovery to share.

12. "Peer-And-Recovery Support" means a distinct health care practice involving intentional partnerships to provide social and emotional support, based on shared experiences of living with behavioral health disorders, Substance Use Disorders, or other

traumas associated with significant life disruption. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.

13. "Peer-And-Recovery Support Specialist" or "PRSS" means an individual trained, credentialed, and qualified to provide Peer/Recovery Support Services within the AHCCCS programs.
14. "Peer Run Organization" or "PRO" means Peer-Operated Services that are:
    a. Independent - Owned, administratively controlled, and managed by Peers.
    b. Autonomous - All decisions are made by the program.
    c. Accountable - Responsibility for decisions rests with the program.
    d. Peer – controlled - Governance board is at least 51%

Peers.

15. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS Members.
16. "Peer Support" means supports intended for enrolled Members or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups.
17. "Whole-Person Care" means a health care delivery system that addresses the full spectrum of an individual's needs – medical, behavioral, socioeconomic, and beyond to encourage better health outcomes.

## POLICY

### A. PEER AND FAMILY INVOLVEMENT AND PARTICIPATION

1. The AdSS shall embed the following principles of Peer and

Family involvement in the design and implementation of an integrated health care delivery system:

a. Providers sharing the same mission to place the Member's whole health needs above all else;

b. Embedding Member and family voice at all levels of the system;

c. Ensuring Members and Family Members have access to Peer Support and Family Support services, utilizing Peer and Family Support Specialists;

d. Reporting PRSS and CFSP Involvement in Service Delivery as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to AMPM Policy 963 and AMPM Policy 964 for requirements regarding the provision of PRSS and CFSP within the AHCCCS program; and

e. Embracing services delivered by individuals with lived experience by maximizing the use PROs and FROs.

2. The AdSS' OIFA shall require Behavioral Health Providers with sites serving multiple Members to have regular and ongoing

Member or family participation to include opportunities for decision-making, quality improvement, and enhancement of customer service.

3. The AdSS shall submit to the Division's OIFA a summary of common activities of Member and family participation at provider sites as identified by AHCCCS, including quality improvement and enhanced customer service developed through the engagement and collaboration of Member and Family Member participation containing:
   a. Agendas;
   b. Meeting minutes; and
   c. Attendance sheets as applicable.
4. The AdSS shall submit the overview of activities as specified in the AHCCCS contract Section F, Attachment F3 Contractor Chart of Deliverables.

## B. COLLABORATION WITH PEERS AND FAMILY MEMBERS

1. The AdSS' OIFA shall hold or attend meetings with a broad spectrum of Peers, Family Members, and providers including

PROs and FROs, advocacy organizations, or any other person(s) having an interest in participating in improving the system, at least every six months for the purpose of:

a. Gathering input;

b. Identifying challenges and barriers;

c. Sharing information; and

d. Strategizing ways to improve or strengthen the service delivery system.

2. The AdSS shall invite Division and AHCCCS OIFAs to participate in meetings organized by the AdSS.

3. The AdSS shall require both Division and AHCCCS OIFAs to be invited to meetings described in this section, when meetings are organized by entities other than the AdSS.

**C. COMMITTEES**

1. The AdSS shall have interactive Peer and Family Member participation on all AdSS Committees, except for those committees that pertain to issues of Member or provider confidentiality, to provide input and feedback for decision

making.

2. The AdSS shall ensure each committee includes two members who are not employed by the AdSS.
3. The AdSS shall make every effort to include representation of council members that reflect the populations and communities served by the Division.
4. The AdSS shall require each AdSS Committee to work with the AdSS' OIFA to include Peers and Family Members enrolled with the AdSS, except for those committees that pertain to issues of Member or provider confidentiality.
5. The AdSS shall submit a Roster of Peer and Family Committee Members as specified in the AHCCCS contract Section F, Attachment F3 Contractor Chart of Deliverables.
6. The AdSS shall ensure that the composition of the recognized Member councils and committees are diverse and representative of the AdSS' current membership throughout the region with respect to the Members' race, ethnic background, primary language, age, and Medicaid eligibility category.

7. The AdSS shall participate in the following committees and councils:
   a. Governance councils;
   b. ALTCS Advisory Council;
   c. Member Advocacy Council (MAC); and
   d. Other existing Councils and organizations as directed by the Division.
8. The AdSS shall invite Division and AHCCCS OIFAs to participate in committee, council, and organization meetings.

## D. PEER RUN ORGANIZATIONS AND FAMILY RUN ORGANIZATIONS

1. The AdSS is required to contract with PROs and FROs, as specified in Contract.
2. The AdSS shall ensure that providers are educated on the role of the PROs and FROs and inform Members on the availability of Peer Support and Family Support Services at PROs and FROs.
3. The AdSS shall ensure Members have access to Peer and Family Support Services that assist with understanding how to effectively utilize the service delivery system to access covered

benefits.

4. The AdSS shall submit a request as specified in the AHCCCS contract Section F, Attachment F3, Contractor Chart of Deliverables for an organization they desire to contract with, that is not currently recognized as a PRO or FRO by AHCCCS/Division of Community Advocacy and Intergovernmental Relations AHCCCS/DCAIR OIFA, and the AdSS believes the organization meets the definition and criteria.

## E. PEER AND FAMILY SUPPORT SPECIALISTS AND FAMILY INVOLVEMENT

1. The AdSS shall embed the following principles of Peer and Family involvement in the design and implementation of an integrated health care service delivery system by requiring:
   a. ASOC that includes adherence to Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems;
   b. CSOC includes conformance with Arizona's Vision-12;
   c. Behavioral, physical, Peer, and Family Support Providers

to share the same mission to place the Member's Whole-Person Care needs above all else, as the focal point of care;

d. Utilization of services provided by Peer and Family Support Specialists and embed Peer and Family voice at all levels of the system, submitting information noting PRSS and Credentialed Parent/Family Support Specialist involvement in service delivery as specified in the AHCCCS Contract, Section F, Exhibit F3: Contractor Chart of Deliverables; and

e. Maximize the use of existing behavioral and physical health infrastructure including PROs and FROs.

2. The AdSS shall report changes made as a result of Member or Family Member participation back to the Members or Family Members served at the site.

**SUPPLEMENTAL INFORMATION**

1. Child and Family Team and Adult Recovery Teams do not fulfill the requirement of providing ongoing Member and Family participation to

include opportunities for decision-making, quality improvement, and enhancement of customer service.

2. Peer and Family involvement opportunities allow for Members to participate in improving experiences and allow for changes to be made.

3. The AHCCCS DCAIR/OIFA will review AdSS requests to recognize PROs and FROS to determine if the provider meets the definition and criteria, as defined in Section C, Definitions and www.SAMHSA.gov.

**ADULT SYSTEM OF CARE - NINE GUIDING PRINCIPLES**

The Adult System of Care (ASOC) is a continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health or substance use challenges. The ASOC is organized into a comprehensive network to create opportunities that foster rehabilitation addressing impairment, managing related symptoms, and improving health outcomes by:

1. Building meaningful partnerships with Members served.
2. Addressing the Member's cultural and linguistic needs, and
3. Assisting the Member in identifying and achieving personal and

recovery goals.

The following principles were developed to promote recovery in the adult behavioral health system. System development efforts, programs, service provision, and stakeholder collaboration shall be guided by these

**NINE GUIDING PRINCIPLES**:

1. RESPECT is the cornerstone. Meet the individual where they are without judgment, with great patience and compassion.
2. INDIVIDUALS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS An individual in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Individuals in recovery should be involved at every level of the system, from administration to service delivery.
3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS An individual in recovery is

held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE An individual in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE An individual in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community

dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY A FOUNDATION OF TRUST An individual in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. INDIVIDUALS IN RECOVERY DEFINE THEIR OWN SUCCESS An individual in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Individuals in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES An individual in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and

sensitive to cultural values and mores. An individual in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY

An individual in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. An individual in recovery is held as boundless in potential and possibility.

**ARIZONA VISION**

In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural

heritage.

**12 PRINCIPLES**

1. COLLABORATION WITH THE CHILD AND FAMILY Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. FUNCTIONAL OUTCOMES Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. COLLABORATION WITH OTHERS When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any

individual important in the child's life who is invited to participate by the child or parents. The team also includes all other individuals needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team:

a. Develops a common assessment of the child's and family's strengths and needs,

b. Develops an individualized service plan,

c. Monitors implementation of the plan, and

d. Makes adjustments in the plan if it is not succeeding.

4. ACCESSIBLE SERVICES Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. BEST PRACTICES Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered

in accordance with guidelines adopted by Arizona Department of Health Services (ADHS) that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. MOST APPROPRIATE SETTING Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's need.

7. TIMELINESS Children identified as needing behavioral health services are assessed and served promptly.

8. SERVICES TAILORED TO THE CHILD AND FAMILY The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. STABILITY Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate

and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. INDEPENDENCE Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self- management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. CONNECTION TO NATURAL SUPPORTS The behavioral health system

identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Signature of Chief Medical Officer: