Section 3.9 Assessment and Service Planning

3.9.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) supports a model for assessment, service planning, and service delivery that is strength-based, person-centered, family friendly, culturally and linguistically appropriate, and clinically sound and supervised. The model is based on four equally important components:

- Input from the person regarding his/her individual needs, strengths, and preferences;
- Input from other persons involved in the person's care who have integral relationships with the person;
- Development of a therapeutic alliance between the person and behavioral health provider that fosters an ongoing partnership built on mutual respect and equality; and
- Clinical expertise.

The model incorporates the concept of a "team", established for each person receiving behavioral health services. For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART).

At a minimum, the functions of the CFT and ART include:

- Ongoing engagement of the person, family and others who are significant in meeting the behavioral health needs of the person, including their active participation in the decision-making process and involvement in treatment;
- An assessment process is conducted to: (a) elicit information on the strengths, needs and goals of the individual person and his/her family, (b) identify the need for further or specialty evaluations, and (c) support the development and updating of a service plan which effectively meets the person's/family's needs and results in improved health outcomes;
- Continuous evaluation of the effectiveness of treatment through the CFT and ART process, the ongoing assessment of the person, and input from the person and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan, including assistance in accessing community resources, as appropriate and, for children, services which are provided consistent with the Arizona Vision and Principles, and for adults, services which are provided consistent with the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;

- Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of services is

important to achieving positive outcomes (e.g., primary care providers, school, child welfare, juvenile or adult probation, other involved service providers);

- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist persons who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor); and

- Development and implementation of transition plans prior to discontinuation or modification of behavioral health services.

3.9.2 Terms

Definitions for terms are located online at http://www.azdhs.gov/bhs/definitions/index.php and http://www.magellanofaz.com/for-providers/provider-manual/definitions.aspx. The following terms are referenced in this section:

Adult Recovery Team
Annual Update
Assessment
Behavioral Health Professional
Behavioral Health Technician
Child and Family Team
Clinical Teams
Credentialing
Family
Initial Assessment
Interim Service Plan
Individual Service Plan (ISP)
Special Assistance

3.9.3 Procedures

3.9.3-A. Assessments

All persons being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For persons who continue to receive behavioral health services, updates to the assessment must occur at least annually. Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual.

ADHS/DBHS does not mandate that a specific assessment tool or format be used but requires certain minimum elements. Providers must collect and submit all required demographic information in accordance with the criteria outlined in the ADHS/DBHS Demographic and Outcome Data Set User Guide (DUG) and Section 7.5, Enrollment, Disenrollment and Other Data Submission.

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral health technician (BHT) under the clinical oversight of a BHP, who are

trained on the minimum elements of a behavioral health assessment and meets requirements in Section 3.20, Credentialing and Recredentialing and Section 9.1, Training Requirements.

Minimum elements of the behavioral health assessment
ADHS/DBHS has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record, in accordance with Section 4.2, Behavioral Health Medical Record Standards:

- Presenting issues/concerns;
- History of present illness, including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
- Medical history;
- Current medications, including over the counter (OTC) medications;
- Allergies and other adverse reactions;
- Developmental history for children/youth under the age of 18 and with other populations if clinically relevant;
- Family history; *
- Educational history/status;*
- Employment history/status;
- Housing status/living environment;
- Social history;*
- Legal history, including custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication;
- Substance abuse history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
- Standardized substance use screen for children age 11 to 18 and referral for comprehensive assessment when screened positive;
- Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) Second Edition – Revised of Patient Placement Criteria (ASAM PPC-2R);
- Labs/diagnostics, if applicable;
- Mental status examination;
- Risk assessment: the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, past history, substance abuse, criminogenic factors, etc.;
- Brief summary/Bio-psycho-social formulation;
- Axial diagnoses I-V;
- Cultural needs (i.e. age, ethnicity, race, national origin, sex (gender), gender identity, sexual orientation, tribal affiliation, disability).
- Date, begin, and end time of the assessment and printed name, signature, and professional credential of the provider completing the behavioral health assessment. If a BHT completes the assessment, the assessment must also include a printed name,

signature, professional credential, date and time of the BHP who reviewed the assessment information.

- REQUIRED FOR ALL TITLE XIX/XXI MEMBERS: Primary Care Provider (PCP) name and contact information.
- REQUIRED FOR ALL TITLE XIX/XXI MEMBERS: Involvement with other agencies (e.g., Child Protective Services (CPS), Probation, Division of Developmental Disabilities (DDD)).
- ONLY REQUIRED FOR CHILDREN AGE 0 TO 5: Developmental screening for children age 0-5 with a referral for further evaluation by the child's Primary Care Provider (PCP), the Arizona Early Intervention Program (AzEIP) for children age 0-3, or the public school system for children age 3-5 when developmental concerns are identified.
- ONLY REQUIRED FOR CHILDREN AGE 6 TO 18: Child and Adolescent Service Intensity Instrument (CASII) score and date.
- ONLY REQUIRED FOR CHILDREN AGE 6 TO 18 WITH CASII SCORE OF 4 OR HIGHER: Strength, Needs and Culture Discovery Document.
- REQUIRED FOR LIMITED ENGLISH PROFICIENCY (LEP) MEMBERS: linguistic needs (i.e. primary language, preferred language, language spoken at home, alternative language).
- ONLY IF INDICATED: Seriously Mentally Ill (SMI) Determination (for persons who request SMI determination or have an SMI qualifying diagnosis and GAF score of 50 or lower) in accordance with Section 3.10, SMI Eligibility Determination.
- ONLY REQUIRED FOR PERSONS DETERMINED SMI: Special Assistance assessment in accordance with Section 5.4, Special Assistance for Persons Determined to Have a Serious Mental Illness.

For persons referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges, in accordance with Section 3.2, Appointment Standards and Timeliness of Service. If the assessor is unsure regarding a person's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with his/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

3.9.3-B. Service Planning

All persons being served in the public behavioral health system must have a written plan for services upon an initial request for services and periodic updates to the plan to meet the changing behavioral health needs for persons who continue to receive behavioral health services. ADHS/DBHS does not mandate a specific service planning tool or format. Service plans must be utilized to document services and supports that will be provided to the individual, based on behavioral health service needs identified through the person's behavioral health assessment.

If a person is in immediate or urgent need of behavioral health services (see Section 3.2, Appointment Standards and Timeliness of Service), an interim service plan may need to be developed to document services until a complete service plan is developed. A complete service plan, however, must be completed no later than 90 days after the initial appointment.

At a minimum, the behavioral health recipient, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative must be included in the development of the service plan. In addition, family members, designated representatives, agency representatives and other involved parties, as applicable, may be invited to participate in the development of the service plan. Behavioral health providers must coordinate with the person's health plan, PCP or others involved in the care or treatment of the individual, as applicable, regarding service planning recommendations (see Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers).

Minimum elements of the service plan for Title XIX/XXI Members and for non-Title XIX/XXI members determined to have SMI that have an assigned Case Manager

Service plans must be completed by BHPs and BHTs who are trained on the behavioral health service plan and meet requirements in Section 3.20, Credentialing and Recredentialing and in Section 9.1, Training Requirements. In the event that a BHT completes the service plan, a BHP must review and sign the service plan.

The service plan must be documented in the comprehensive clinical record in accordance with Section 4.2, Behavioral Health Medical Record Standards, be based on the current assessment, and contain the following elements:

- The person/family vision that reflects the needs and goals of the person/family;
- Identification of the person's/family's strengths;
- Measurable objectives and timeframes to address the identified needs of the person/family, including the date when the service plan will be reviewed;
- Identification of the specific services to be provided and the frequency with which the services will be provided;
- The signature of the person/guardian and the date it was signed;
- Documentation of whether or not the person/guardian is in agreement with the plan;
- The signature of a clinical team member and the date it was signed;
- The signature of the person providing Special Assistance, for persons determined to have Serious Mental Illness who are receiving Special Assistance (see Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness);
- The Service Plan Rights Acknowledgement, dated and signed by the person or guardian, the person who filled out the service plan, a designated representative or advocate (if any), and a behavioral health professional if a behavioral health technician fills out the service plan.

The behavioral health recipient must be provided with a copy of his/her plan. Behavioral health recipients may contact Magellan Member Services at 1-800-564-5465, or TTY 1-800-424-9831, regarding any questions they may have about their service plan and rights.

Minimum elements of the service plan for Non-Title XIX/XXI persons determined to have SMI that do not have an assigned Case Manager

Service plans for Non-Title XIX/XXI persons determined to have SMI who do not have an assigned Case Manager can be incorporated into the psychiatric progress notes completed by the BHP as long as the treatment goals reflect the needs identified on the assessment, are clearly documented, and summarize the progress made. The BHP must document when a

clinical goal has been achieved and when a new goal has been added. The service plan must be reviewed, at a minimum, once a year.

Appeals or Service Plan Disagreements
Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member and results in consensus regarding the type, mix and intensity of services to be offered. In the event that a person and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should take reasonable attempts to resolve the differences and actively address the person's and/or legal or designated representative's concerns.

Despite a behavioral health provider's best effort, it may not be possible to achieve consensus when developing the service plan. In cases that the person and/or legal or designated representative disagree with some or all of the Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative **must** be given:

- A Notice of Action (PM Form 5.1.1) by the behavioral health representative on the team.

In cases that a person determined to have SMI and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative **must** be given:

- PM Form 5.5.1, Notice of Decision and Right to Appeal (For Individuals With a Serious Mental Illness), by the behavioral health representative on the team.

In either case, the person and/or legal or designated representative may file an appeal within 60 days of the action.

3.9.3-C. Updates to the Assessment and Service Plan
Behavioral health providers must complete an annual assessment update with input from the behavioral health recipient and family, if applicable, that records a historical description of the significant events in the person's life and how the person/family responded to the services/treatment provided during the past year. Following this updated assessment, the service plan should then be updated as necessary. While the assessment and service plan must be updated at least annually, the assessment and service plan may require more frequent updates to meet the needs and goals of the behavioral health recipient and his/her family.

3.9.4 References
The following citations can serve as additional resources for this content area:

9 A.A.C. 20
9 A.A.C. 21
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.2, Appointment Standards and Timeliness of Service
Section 3.5, Third Party Liability and Coordination of Benefits
Section 3.10, SMI Eligibility Determination

Section 3.20, Credentialing and Recredentialing
Section 4.2, Behavioral Health Medical Record Standards
Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers
Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness
Section 7.5, Enrollment, Disenrollment and Other Data Submission
Section 9.1, Training Requirements
ADHS/DBHS Covered Behavioral Health Services Guide
ADHS/DBHS Demographic and Outcome Data Set User Guide (DUG)
ADHS/DBHS Practice Protocol, Child and Family Team Practice
ADHS/DBHS Practice Protocol, Working with the Birth to Five Population
Arizona Vision and Principles
9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems

PM Attachment 3.9.1

Service Plan Rights Acknowledgment Template[i]

Service Plan Rights Acknowledgement for Persons who are Title XIX/XXI and/or SMI:
My service plan has been reviewed with me by my behavioral health provider. I know what services I will be getting and how often. All changes in the services have been explained to me. I have marked my agreement and/or disagreement with each service. I know that in most cases, any reductions, terminations, or suspensions (stopping for a set time frame) of current services will begin no earlier than 10 days from the date of the plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that on my plan. I know if the service asked for was denied, reduced, suspended or terminated, that my behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can request continued services.

My behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights.

I know that if I need more services or other services than what I am getting, I can call my behavioral health provider at (____) ____ - _____ to talk about this. My behavioral health provider will call me back within 3 working days. Once I have talked with my behavioral health provider, s/he will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

Información sobre los derechos contenidos en el plan de servicios para personas que están cubiertas bajo los títulos XIX/XXI y/o SMI:
Mi plan de servicios ha sido revisado conmigo por mi proveedor de servicios de salud mental. Sé cuales servicios voy a obtener y cada cuanto tiempo. Todos los cambios en el plan de servicios me han sido explicados. He mencionado mi acuerdo o desacuerdo con cada uno de los servicios. Sé que en la mayoría de los casos, cualquier reducción, terminación o suspensión (detenidos por un tiempo determinado) de los servicios actuales no comenzará antes de 10 días a partir de la fecha del plan. Sé que puedo pedir que ésto suceda antes.

Si no estoy de acuerdo con algunos o todos los servicios que han sido autorizados en éste plan. Sé, que si el servicio pedido ha sido negado, reducido, suspendido o terminado, mi proveedor de servicios de salud mental me entregará una comunicación en la que me informará por qué fue tomada la decisión. Esta carta me indicará cómo apelar la decisión que ha sido tomada en relación a mis servicios. La carta también me informará sobre cómo puedo solicitar la continuidad de los servicios.

Mi proveedor de servicios de salud mental me ha informado acerca de cómo funciona el proceso de apelaciones. Yo sé cómo apelar acerca de cambios en el servicio con los cuales no estuve de acuerdo. Entiendo, que puedo cambiar de opinión después, acerca de servicios con

los que hoy estuve de acuerdo. Sé, que si cambio de opinión antes de que los cambios se hagan efectivos, recibiré una carta explicando la razón por la cual mis servicios fueron cambiados. La carta también tendrá información acerca de mis derechos de apelación.

Sé, que si necesito servicios adicionales u otros servicios diferentes de los que he estado recibiendo, puedo llamar a mi proveedor de servicios de salud mental al ( )_____ para hablar acerca de éste tema. Mi proveedor de servicios de salud mental regresará mi llamada dentro de los siguientes tres días hábiles. Una vez que haya hablado con mi proveedor de servicios de salud mental, éste me dará una decisión acerca de mi solicitud dentro de un plazo de 14 días. Si el proveedor de servicios de salud mental no ha podido tomar una decisión acerca de mi solicitud dentro de los 14 días, entonces me enviará una carta para informarme que se necesita más tiempo para tomar la decisión.

[i] The template may only be modified to include information, as indicated in the template, or to modify the language if a parent or guardian is reviewing and signing the acknowledgment on behalf of the behavioral health recipient.