## Section 3.9 Assessment and Service Planning



## I. STATEMENT OF PURPOSE:

The Pascua Yaqui (PY) Centered Spirit Program (CSP) 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:

1. Input from the client regarding his/her individual needs, strengths, and preferences;

2. Input from other persons involved in the client's care who have integral relationships with the client;

3. Development of a therapeutic alliance between the client and the behavioral health provider that fosters an ongoing partnership built on mutual respect and equality; and

4. Clinical expertise.

The model incorporates the concept of a "team," established for each person receiving behavioral health services. For children, this team is the Centered Spirit Program's 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 client, family, and others who are significant in meeting the behavioral health needs of the person, including their active participate in the decision-making process and involvement in treatment;

- An assessment process is conducted to:
    - Elicit information on the strengths, needs and goals of the client and his/her family;
    - Identify the need for further or specialty evaluations; and
    - Support the development and updating of an Individualized Service Plan (ISP) which effectively meets the client's/family's needs and results in improved health outcomes.
- Continuous evaluation of the effectiveness of treatment through the CFT and ART team process, the ongoing assessment of the client, and input from the client and his/her team, resulting in modification to the ISP, if necessary.
- Provision of all covered services as identified on the ISP, including assistance in accessing community resources, as appropriate;
- 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.

## II. REFERENCES:

The following PY/CSP Provider Manual sections can serve as additional resources for this content area:

*Section 3.10, SMI Eligibility Determination*
*Section 4.2, Behavioral Health Medical Record Standards*
*Section 4.3, Coordination of Care with AHCCCS Health Plans and Primary Care Providers*
*Section 3.7, Clinical Liaison*
*Section 3.20, Credentialing and Re-Credentialing*
*Section 7.5, Enrollment, Disenrollment and Other Data Submission*

*Section 4.1, Disclosure of Behavioral Health Information*
*Section 3.6, Member Handbooks*
*Section 3.1, Accessing and Interpreting Eligibility and Enrollment Information and Screening and Applying for AHCCCS Health Insurance*
*Section 3.11, General and Informed Consent to Treatment*

The following AHCCCS document also serves as a resource for this content area:

AHCCCS/TRBHA Intergovernmental Agreement (IGA) of 2021

## III. STANDARDS:

Assessments and treatment plans:

- Are developed with and unconditional commitment to persons enrolled in the behavioral health system and their families;
- Begin with empathic relationships that foster ongoing partnerships and expect equality and respect throughout the service delivery system;
- Processes include other individuals important to the person served; and
- Are individualized, strength-based, culturally appropriate and clinically sound and are developed with the expectation that the person is capable of positive change, growth and leading a life of value;
- Assessments are completed prior to initiating services;
- When an assessment is received that was completed prior to 12 months before current admission and meets paperwork requirements, information is reviewed and updated and the review and update is documented within 48 hours in the Electronic Health Record (EHR).

## IV. PROCEDURES:

A. Assessments:

Behavioral health providers must conduct assessments that address the general components described in the introduction subpart of this section. CSP has modified the previously established but no longer required standardized AHCCCS assessment that includes a “core” assessment and several additional assessment documents, or “addenda” that must be completed as applicable for specific populations.

The initial and annual assessment must be completed by a behavioral health medical provider (BHMP), behavioral health clinician (BHC), or behavioral health technician (BHT) under the clinical oversight of a BHCC who is trained on the

minimum elements of a behavioral health assessment and meets requirements in *Section 3.20, Credentialing and Re-Credentialing.* If an assessment is conducted and documented by a BHT, a BHC must review and sign the assessment information that was documented by the BHT within 72 hours.

There are possible exceptions to completing the core assessment at the initial appointment. In an emergency or crisis situation, the person's immediate clinical needs must be initially addressed. To ensure the person's safety, any person who shows evidence of depressed mood, anxiety, or substance abuse should be specifically assessed for suicidal risk. The assessor should complete the Special Suicide Risk Assessment Addendum at this time. At other times, it may be necessary to provide needed behavioral health services before completing the core assessment necessary to provided needed behavioral health services before completing the core assessment (e.g., appointments with a BHMP to assess the need for and/or to provide psychotropic medications). In these cases, the core assessment can be completed at the next appointment.

Additionally, if a client presents with issues that are determined to be immediate medical concerns, or if the behavioral health issue appears to be related to an immediate medical concern, the client is referred to a medical practitioner.

Additionally, for urgent responses to children removed from their homes by the Pascua Yaqui Child Protective Services (PY CPS) or the Arizona Department of Economic Security/Child Protective Services (DES/CPS), the priority at the initial interview is to address the child's immediate needs. At a minimum, the assessor should try and complete the CPS addendum along with the following Core Assessment sections of the General Assessment for children age 5 and older:

- Risk Assessment;
- Mental Status Exam;
- Clinical Formulation and Diagnosis; and
- Next Steps/Interim Service Plan.

For children younger than 5, the assessor should complete:

- CPS Addendum;
- Behavioral Health Client Sheet;
- Client Demographic Information Sheet; and
- Core Assessment of the Birth-5 Assessment, including

- Risk Assessment Observations;
- Reported Observations of the Child (and if possible, Observations of the Family-Child Interaction);
- Diagnostic Summary; and
- Next Steps/Interim Service Plan.

The remainder of the Core Assessment should only be completed at this time if the child's clinical condition or circumstances allow. The assessor should make sure that Child Protective Service Specialist's name and phone number is recorded on the Cover Sheet.

B. Other components of the assessment process:

- BHCs must use the CSP Core Assessment. BHCs may reformat the standardized assessment and re-order questions to adjust to individual situations, however, the basic topic areas and individual questions must be covered.
- A credentialed and privileged BHT or BHC must conduct the initial assessment. This person must serve as the Clinical Liaison unless/until another credentialed and privileged BHT or BHC is more appropriately matched to serve permanently in this capacity.
- 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. 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 a licensed medical practitioner with prescribing privileges.
- Providers are expected to be in compliance with timelines for services and appointments, including:
  - Completion of the other required addenda either at the initial appointment or during subsequent meetings. The addenda are completed depending on the individual needs of the person, but it is expected that a comprehensive assessment allowing for sound clinical formulation and diagnostic impression must be completed within 45 days of the initial appointment. For persons seeking a determination for serious mental illness, the entire assessment will need to be completed at the initial appointment, while several meetings may be necessary to complete an assessment for a child being served by multiple agencies;

  - Required data element submission within 45 days; and
  - Completion of the person's initial service plan no later than 90 days after the initial appointment.

- Documentation of the assessment in the comprehensive clinical record within 48 hours of completion of the assessment appointment;
- If a BHT completes the assessment, the information must be reviewed by a credentialed and privileged BHC; and
- Coordination with the person's PCP regarding assessment recommendations;
- If the risk assessment indicates a need for a safety plan, one is developed as soon as possible that identifies triggers, including assessment of the risk for dangerous behaviors, current coping skills, warning signs, preferred interventions and, as available, advance directives.

A credentialed and privileged BHT or BHC must be assigned to conduct the assessment of children birth to 5 (see *Section 3.20, Credentialing and Re-Credentialing*).

The following addenda (see Form 3.9.2, Part B) are contained within the Birth to 5 Behavioral Health Assessment (see Instruction Guide for the Assessment: Birth to 5, ISP and Annual Update for detailed instructions):

- Family Culture and History Addenda;
- Developmental Checklist or Ages and Stages Questionnaire;
- Behavioral Analysis;
- Medical Care; and
- Child Protective Services.

After children turn 5, teams may use the Annual Update Form from either the Birth to 5 Assessment or the General Assessment for annual updates until the child turns eight years old. For the annual update done during the child's eighth year and beyond, the Annual Update Form from the General Assessment must be used. During the child's tenth year, it is required that the full General Assessment be administered; and children who have already turned five years old by the time are referred to the TRBHA must have the General Assessment.

C. Individual service planning:

Behavioral health providers in conjunction with the person's team must develop and implement ISPs based on a person's initial and ongoing assessments.

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 ISP is developed. A complete ISP, 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 ISP. In addition, family members, designated representatives, agency representatives and other involved parties, as applicable, may be invited to participate in the development of the treatment 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 and Primary Care Providers*). The ISP must address the general components in the introduction subpart of this section. CSP follows a standardized treatment plan format.

The ISP is based on the results of evaluation and assessment conducted prior to the development of the plan.

For children, assessment information and recommendations contained in the following documents will be considered in the development of the plan:

a. The individualized education program (IEP);

b. The child welfare case plan (CPS);

c. The juvenile probation or parole case plan;

d. The medical plan from the primary care physician;

e. The individual service plan (DDD); and

f. Any other plans of care designed to meet the needs of the child.

The individual service/treatment plan identifies:

- Measurable goals and objectives;
- Dates by when achievement of those goals and objectives is expected;

- Specific services and activities intended to assist the client in achieving those goals; and

- Providers involved in the delivery of services delineated in the plan.

Minimum elements of the ISP for Title XIX/XXI Members and for non-Title XIX/XXI members determined to have SMI that have an assigned BHT:

ISPs must be completed by BHMPs, BHCs or BHTs who are trained in the behavioral health plan and meet requirements in *Section 3.20, Credentialing and Recredentialing.* If a BHT completes the ISP, a BHC must review and sign the ISP.

The ISP 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;

- Identification of the specific services to be provided and the frequency with which the services will be provided;

- The signature of the parent/guardian and the date it was signed;

- Documentation whether 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 (SMI)*); and

- The Service Plan Rights Acknowledgement (see Attachment 3.9.1, Service Plan Rights Acknowledgement template), dated and signed by the person or guardian, the person who filled out the ISP, and a BHC if a BHT fills out the ISP.

The behavioral health recipient must be provided with a copy of his/her plan.

Minimum elements of the ISP for Non-Title XIX/XXI persons determined to have SMI who do not have an assigned BHT:

ISPs for Non-Title XIX/XXI persons determined to have SMI who do not have an assigned BHT can be incorporated into the psychiatric progress notes completed by the BHMP as the treatment goals reflect the needs identified on the assessment, are clearly documented, and summarize the progress made. The BHMP must document when a clinical goal has been achieved and when a new goal has been added.

Additionally, Non-Title XIX/XXI persons determined to have SMI, who not have an assigned BHT shall have the option of accessing peer support services to assist them in developing a peer-driven, self-developed proposed ISP to be shared with their BHMP for approval, adoption, and implementation. These peer-driven, self-developed ISPs are not required to contain all minimum elements as outlined above for those that have assigned BHTs; however, they should consider the member-specific needs for and expected benefits from community-based support services including, but not limited to supported employment, peer support, family support, permanent supportive housing, living skills training, health promotion, personal assistance, and respite care. Peer-driven, self-developed proposed ISPs should also address natural supports that can be leveraged and strengthened as well as outline crisis prevention approaches (e.g., warm line availability) and how the emergency of a potential crisis will be addressed.

These services should be incorporated into the peer-driven, self-developed proposed ISP as appropriate. It is recommended that a standardized process be used to develop peer-driven, self-developed proposed ISPs.

Additionally, the peer-driven, self-developed proposed ISP must be reviewed with and approved by the BHMP and maintained in the medical record. Progress and outcomes related to the approved peer-driven, self-developed ISP must be tracked and documented by the BHMP.

What if the person and/or legal or designated representative disagree with the ISP?

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. If a person and/or legal or designated representative disagree with any aspect of the ISP, 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 ISP.

In cases that the person and/or the legal or designated representative disagree with some/all of Title XIX/XXI covered services included in the ISP, 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 a Serious Mental Illness and/or legal or designated representative with some/all of Non-Title XIX-XXI covered services included in the ISP, the person and/or legal or designated representative **must** be given:

- PM Form 5.5.55*, 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.

If the services identified in the ISP are not currently available, the clinical team develops an alternative plan for interim services. For persons who have been determined to have a serious mental illness, the plan is developed in accordance with A.A.C. R9-21-209.

The clinical liaison identifies providers of service included in the ISP and consistent with the evaluation of need. The ISP is reviewed on a regular basis to determine if the services continue to be consistent with the person's needs and least restrictive of the person's freedom.

The case coordinator or BHTs as part of the individual service/treatment plan shall develop a transition plan anticipating the discharge of services.

D. Other components of the service planning process:

- Behavioral health providers must incorporate the elements identified within the ISP and review of the progress format.
- If a BHT completes the ISP, a credentialed and privileged BHC must review the plan.
- Initial ISPs must be completed no later than 90 says after the initial appointment.
- Documentation of the service planning information must be in the comprehensive clinical record.

- Coordination with the person's PCP regarding service planning must take place as appropriate and required.

E. Updates to the assessment and ISP:

Behavioral health providers must complete an annual update 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 ISP should then be updated as necessary. While the assessment and ISP must be updated at least annually, the assessment and ISP may require more frequent updates to meet the needs and goals of the behavioral health recipient and his/her family. The updated assessment is documented within 48 hours of completion.

The update process includes the following requirements:

- Use of the AHCCCS standardized annual behavioral health update and review summary that is completed by the person's Clinical Liaison or designee with the person and other relevant participants present;

- Behavioral health providers may reformat the annual update and re-order the questions to adjust to individual situations; however, the basic topic areas of each question must be covered;

- Share, as appropriate, this information with other key individuals or entities such as the person's primary care physician, or DES/DDD BHT and

- Documentation of the annual update and service must be in the comprehensive clinical record.