
State and Local Descriptions

I. Sample Sites Using State-Developed Guidelines

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Overview

The state of Arizona initiated a process in 2001 to substantially redesign its process of mental health and substance abuse service delivery to children and adolescents. The state already possessed a unique behavioral health infrastructure due to the combined challenges of urban and rural needs, tribal and non-tribal cultures, and linguistically diverse populations. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) is the single state authority to provide coordination, planning, administration, regulation and monitoring of all facets of the state public behavioral health system. ADHS/DBHS contracts with five separate organizations, known as Regional Behavioral Health Authorities (RBHAs), and three additional organizations, known as Tribal Regional Behavioral Health Authorities (T/RBHAs), to administer behavioral health services throughout six specified geographic service areas and three Tribal service areas. These RBHAs and T/RBHAs function in a fashion similar to a managed care behavioral health carve-out, contracting with a network of service providers to deliver a full range of behavioral health care services for adults and children, including children with serious emotional disturbance¹⁷.

Known as the “Arizona Vision,” the new comprehensive vision for caring for the state’s children is built on twelve principles to which ADHS and AHCCCS (Arizona Medicaid) are both obligated and committed. These principles are a modification of the original CASSP Principles articulated by Stroul and Friedman in 1986¹⁸ and emphasize the necessity of orienting service delivery around a “system of care” approach. To be consistent with the state’s new vision, the Arizona Department of Health Services/Division of Behavioral Health Services has worked aggressively to significantly revise and standardize its intake, assessment and service planning processes. In an effort to support implementation of these changes, the state developed the strengths-based Arizona Uniform Behavioral Health Assessment¹⁹ tool, which has been in use since January of 2004. Additionally, Arizona has developed and defined and is testing and standardizing a wraparound practice, called the Child and Family Team process, to be the foundation of its new system of care.

¹⁷ More information on the Arizona public behavioral health system may be found on the Arizona Department of Health Services website at: www.azdhs.gov/bhs/index.htm

¹⁸ Stroul, B. A.; Friedman, R. M. (1986). A system of care for severely emotionally disturbed children & youth (ED 330167). Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center: U.S. Dept. of Education, Office of Educational Research and Improvement, Educational Resources Information Center.

¹⁹ Arizona Department of Health Services, Division of Behavioral Services (December 07, 2004). ADHS/DBHS Revised Assessment Process. Available http://www.azdhs.gov/bhs/assess_process <http://www.azdhs.gov/bhs/assess_process>.

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The state also developed and is implementing related Practice Improvement Protocols, consistent with the “Arizona Vision.” A recent example is directed toward providers of services to children in therapeutic foster care, with targeted areas of improvement framed in the context of the twelve principles.

Goals

The Arizona Vision is summarized on the state website, where it is described as having the following goals and objectives:

“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 and family’s cultural heritage.”

New instruments and protocols needed to be created to support these goals, since existing methodologies were not deemed sufficiently strengths-based or family driven. The reconfiguration of the public sector behavioral health system is intended to ensure that every child in the system will be served by a child and family team.

Background

In Arizona, the 1997 suicide mortality rate among adolescents 15–19 years old was 23.7 per 100,000, the second highest rate in the U.S. This, along with other consumer concerns, helped fuel a class action suit regarding state obligations inherent in the federal EPSDT regulations to screen for and treat child mental health needs. Arizona had been constrained for the previous 23 years by the impact of an earlier lawsuit regarding adequacy of adult behavioral health services and did not wish to repeat that experience. Instead, in 2001, the federal suit, referred to as “Jason K” was settled; the “Arizona Vision” and the twelve principles were the foundation of the Jason K settlement agreement. In the process of reforming the public behavioral health system, the Arizona Department of Health Services has used the expertise of the Office of the Medical Director, the Children’s Bureau, and the Office of Quality Management. These three entities collaboratively provide development, implementation, enforcement, monitoring, and clinical oversight of the state’s behavioral health service provision. Working closely with the Medical and Clinical Directors of the RBHAs, as well as providers, clinicians from other State agencies, and family members, the Office of the Medical Director has established guidelines for treatment and non-categorical service delivery, quality of care measurement, and best practice standards throughout the State. The Medical Director and Associate Medical Director coordinate with the AHCCCS (i.e., Medicaid) Medical Director and AHCCCS Health Plans for the joint management of clients’ physical and behavioral health needs. The Associate Medical Director is responsible for children’s behavioral health issues.

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Over a period of eighteen months, a work-group of consumers, providers and family members developed the Arizona Uniform Behavioral Health Assessment tool for persons five years old and up. A second group developed a parallel assessment tool for children below the age of five, which was piloted in September of 2004 and anticipated to be rolled out state-wide in 2005.

Description

As part of an AHCCCS contract deliverable, the state has instituted annual administrative review and audit of service use. In order to facilitate this, it was clear that the state needed a new assessment tool. As noted, the new tool is based on clinical experience, consumer review, expert opinion and common elements within known instruments. Guidelines are not used in Arizona to represent either a floor or a ceiling for service provision. The state does not use level-of-care criteria and rejected the proposed use of the CALOCUS (now called the CASII) because it was deemed at odds with “voice and choice” by family members. The only exception to this is for Level I care: defined as Acute Hospital and Locked Residential. These settings are required by Federal legislation to have prior authorization. AHCCCS (Arizona State Medicaid) contracts with the Arizona Department of Health Services, to oversee the provision of behavioral health by chosen vendors (RBHAs), who then subcontract, through varied mechanisms, with providers. Level I admission and “continued stay” criteria are determined by the Arizona Department of Health Services.

The Arizona Behavioral Health Assessment tool lays out a number of clinical decision making guidelines for RBHAs and their contracted providers. As of July 2003, assessment and service planning was expected to be strengths-based and person/family centered. An interim service plan, built upon a clinical formulation, was to be developed with an emphasis on immediate needs. On-going service planning is to follow, using a team approach in a culturally competent manner.

Key to this process is the Core Assessment. The purpose of the Core Assessment is to collect enough information to “ensure safety and get the person to the appropriate next service(s).”²⁰ The areas covered by the Core Assessment include:

- (1) presenting concerns,
- (2) behavioral health and medical history,
- (3) criminal justice,
- (4) substance related disorders,
- (5) abuse/sexual risk behavior,
- (6) risk assessment,

²⁰ Arizona Department of Health Services, Division of Behavioral Services (December 07, 2004). ADHS/DBHS Revised Assessment Process. Available http://www.azdhs.gov/bhs/assess_process <http://www.azdhs.gov/bhs/assess_process>.

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- (7) mental status exam,
- (8) clinical formulation and diagnoses,
- (9) next steps/interim service plan.

In essence, the Core Assessment serves as a triage tool, ensuring that the most appropriate next steps are identified, with the youth's immediate needs provided for until a comprehensive assessment, required within 45 days, can be completed.

All completed assessments include documentation of the living environment, employment or educational/vocational status, strengths, social/cultural features, and developmental history. When "triggered" by the information collected, additional aspects documented are the presence of criminal justice involvement, eligibility for determination of Serious Mental Illness (SMI), or special services provided within 24 hours to children removed from their homes by Child Protective Service activities. All SMI determinations are reviewed by either a psychiatrist or a psychologist.

The Clinical Formulation and Diagnoses section within the Core Assessment was developed to define a preliminary construct of the nature of the individual's strengths and weaknesses, and the relative contribution of all assessed areas (developmental, health and social history, family relationships, family functioning and cultural patterns, family psychosocial and medical history and personal traits, etc.) to these strengths and weaknesses. In a succinct paragraph, the assessor is expected to provide a descriptive picture of the individual by summarizing, not repeating, accumulated data collected and most importantly, making sense of it. If done correctly, this section ties together disconnected details, historical facts and observations that have been collected to this point, organized to create a clinically pertinent conceptual portrait of the child for use in service plan development. A diagnostic summary, based on the multi-axial system and including Global Assessment of Functioning (GAF) or Child Global Assessment scores (CGAS), is included.

The Interim Service Plan stemming from the Core Assessment is made up of recommended next steps, including the core team's suggested response to immediate risks. There is also room to note recommended additional team members and the person to contact for immediate assistance. Additional service goals may be added or completed at follow-up meeting(s). Goals are drawn from an examination of life domains, with further identification of strengths and additional supports to build "a complete picture."

The Core Assessment is built on the premise that the assessment process must be an ongoing one, and that the information necessary to develop a meaningful, comprehensive, clinically sound and family focused service plan must be developed over time and in the context of a Child and Family or Adult Team. Thus, a first step in the interim service plan is the development of these teams. Following the Core Assessment, an individualized ongoing Service Plan is established based on continuing assessment. The Service Plan is documented on a standardized form that involves the youth, the family and the team. The form captures identified objectives, outcome measures and target dates for achievement. Progress is regularly

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reviewed and objectives revised if necessary. At a minimum, annual updates are done using a standardized form for addressing a services and treatment summary, current clinical status including diagnosis, and all recommendations.²¹

Individualized, Culturally Competent Family Focus

Stakeholders in the state's reform process felt that the old state guidelines were overwhelmingly diagnosis-driven and not family-driven. This did not fit the Arizona Vision, so new guidelines were created to better respond to the new model of care and the expectations set by the Twelve Principles. The Child and Family Teams are built upon the premise of care delivery that is individualized based on need and family culture. A professional "Clinical Liaison" is assigned to each Child and Family Team with the goal of creating a link between the Team's objectives and identified needs and the providers or other available resources. The Clinical Liaison also contributes clinical expertise and recommendations to help guide comprehensive team decision-making.

Impact of Service Availability

As a result of the federal EPSDT based lawsuit, Arizona Medicaid has significantly broadened the array of covered services, and clinical guidelines have been set with an expectation of increased access. Some providers reportedly still limit care, however, due to provisions in their managed care contracts with the RBHAs. However, if a service is not readily available, the state guidelines require the child and family team to either try elsewhere to find the service or create an alternative.

Training, Fidelity and Oversight

An instruction manual for the assessment and planning instruments is provided to all practitioners (i.e., clinical supervisors, assessors and/or clinical liaisons). It provides an in-depth understanding of how to effectively and efficiently put the tools to use. The guide addresses the purpose of each component of the tools, along with the intent behind the individual questions. For assessment-related questions, examples of additional probes are provided that assessors may choose to use to solicit information.

There was extensive statewide training for providers on the assessment tool both in-person and via videotapes. The implementation plan was to phase-in use of the tool after the initial trainings, with full implementation by March 2004. A second wave of training moved beyond basic assessment skills to enhanced assessment training, and provided follow-up technical assistance. ADHS worked collaboratively with the Arizona Office of Behavioral Health Licensing to define credentialing and privileging criteria, based in part on these additional trainings, to expand the types of practitioners qualified to do assessments. Specific Practice Improvement Protocols were created as part of another statewide training effort. Newly developed Technical

²¹ Arizona Department of Health Services, Division of Behavioral Services (December 07, 2004). ADHS-DBHS behavioral health assessment and service plan checklist. Available http://www.azdhs.gov/bhs/assessment/assess_tool.doc <http://www.azdhs.gov/bhs/assessment/assess_tool.doc> .

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Assistance Documents, planned to complement Practice Improvement Protocols, addressed administrative and operational issues confronting providers.

Some monitoring and supervision about use of the guidelines was built into contracts with the RBHAs and T/RBHAs. RBHAs undergo annual clinical and administrative reviews of their work. They are also monitored via chart reviews, audits, independent case reviews, bi-annual consumer satisfaction surveys, and ongoing quality management oversight. A quality management workgroup is in the process of developing clinical supervision standards for Child and Family Teams, fidelity measures for Child and Family Team process, and process outcome indicators. The Wraparound Fidelity Index (WFI)²² is currently being used in some of the settings to measure fidelity to the Child and Family Team process (the wraparound model consistent with Arizona's Twelve Principles.)

Experience to Date

The clinical guidelines used in Arizona were developed to support the Twelve Principles, facilitate quality management and encourage consistency of service provision. They were not written to capture or manage cost, and the cost implications of implementing the Vision have yet to be measured.

With the new system in place, work has begun to try to monitor adherence to Practice Improvement Protocols (e.g. measurement of compliance with the “urgent response” protocol required when children are removed from their homes by child welfare).

An independent auditor is using performance measures to evaluate:

- (1) child and family team development,
- (2) cultural competency,
- (3) member and family care experience,
- (4) appropriateness of care and
- (5) access.

The Arizona Department of Health Services Policy Office, with oversight by the Medical Director's Office and input from behavioral health consumers, family members, and providers, reviews guidelines on a regular and as-needed basis.

Participants in developing the “Arizona Vision” report that the experience taught them it was crucial to communicate clearly from the outset how the guidelines are intended to be used. Are they “recommendations” or are they “mandates”? Will there be monitoring against them? They also found it valuable to consider existing “best practices” located elsewhere. This led Arizona policy makers to recognize that need and strengths driven care, tied to the wisdom of families, was what would help the state system the most. The ADHS Policy Office is now working with the Medical Directors office and Clinical Bureaus to revise service planning guidelines and Practice

²² Bruns, E., Suter, J., Burchard, J., Force, M. & Leverentz-Brady, K. (2004). Assessing fidelity to community-based treatment for youth: the Wraparound Fidelity Index. *Journal of Emotional and Behavioral Disorders*. 12, 69-79. The Wraparound Fidelity Index also may be downloaded from the following website: <http://depts.washington.edu/wrapeval/WFI.html>

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Improvement Protocols to more carefully outline the Department's expectations as well as its requirements.

Major Benefits, Concerns and Lessons Learned

Arizona stakeholders described a number of **benefits** associated with the use of the new guidelines, including:

- They promote and extend the “Vision” of how the state’s children and families should be served
- They instill core values (the Arizona Principles) into all components of service delivery
- They have changed the paradigm of care delivery in the state
- Treatment planning is less of a “random act” and instead can be supported to become more consistent
- Structured guidelines promote development of quality improvement processes and outcomes measurement

Stakeholders also identified the **challenges** of implementing the new guidelines, including:

- Analyzing, understanding and addressing the cost of discarding the old procedures and putting new ones in place
- The effort involved in training, re-training and coaching providers and administrators on the new practice approach.
- Intrinsic resistance to the “team” approach and partnering with families
- Previous paradigm of “experts” deeply entrenched
- Adjusting the quality management system and supervision protocols in order to monitor and reinforce adherence and fidelity after the training phase is over

Additional issues surfacing from early audits and chart reviews include finding that the new Assessment and Service Planning processes are not being uniformly used in all geographic service areas. It appears that, despite intensive training, the new assessment tool is not yet being fully used as intended regarding both cultural competency and service planning. An unrelated concern post-implementation has arisen during a review of authorizations. This review suggests that some providers themselves are using prior authorization processes in a manner that creates barriers to full access to care, even though the state has tried to remove such barriers. The issue is multi-textured. Part of it may stem from the difficulty, in general, of moving a provider system to a new service paradigm. Part may also be related to the fact that the RBHAs are capitated systems; the amount they pay providers (or that the state pays RBHAs) may not be sufficient to fully implement the new guidelines and practice expectations. State-level stakeholders indicated that further efforts to partner with the RBHAs and providers will be required to address this issue.