



## Supplemental Clinical Criteria: Arizona Medicaid

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### INSTRUCTIONS FOR USE

The following *State or Contract Specific Clinical Criteria*<sup>1</sup> defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

Other *Clinical Criteria*<sup>2</sup> may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®<sup>3</sup>. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

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<sup>1</sup> **Clinical Criteria (State or Contract Specific):** Criteria used to make medical necessity determinations for mental health disorder benefits when there are explicit mandates or contractual requirements.

<sup>1</sup> **Clinical Criteria for Arizona**  
**LOCUS/CALOCUS-CASII/ECSII for Mental Health Disorders**  
**ASAM Criteria for Substance Use Disorders**

<sup>1</sup> Optum is a brand used by United Behavioral Health and its affiliates.

## **APPLIED BEHAVIOR ANALYSIS**

Behavior Analysis Services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. Behavior Analysis Services are designed to accomplish one or more of the following: increase functional skills, increase adaptive skills (including social skills), teach new behaviors, increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health needs. Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

### **BEHAVIOR ANALYSIS ASSESSMENTS**

**Behavior Analysis Services shall be based upon assessment(s) that include Standardized and/or Non-standardized instruments through both direct and indirect methods.**

1. Standardized instruments and procedures include, but are not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all members (e.g. Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).
2. Non-standardized instruments and procedures include, but are not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual member and their behaviors. This may also include functional behavioral analysis done in an inpatient or residential setting in preparation for ABA treatment as an outpatient.

### **SERVICE ADMINISTRATION**

**Behavior Analysis Services shall be rendered in accordance with an individualized behavior analysis treatment plan will:**

1. Be developed by a Behavior Analyst, based upon an assessment completed of the member and their behaviors as described above.
2. Be person-centered and individualized to the member's specific needs.
3. Specify the setting(s) in which services will be delivered.
4. Identify the modality by which the service will be delivered (whether in person or via telehealth, or in group or individual setting, or combination thereof).
5. Identify the baseline levels of target behaviors.
6. Specify long- and short- term objectives that are defined in observable, measurable, and behavioral terms.
7. Specify the criteria that will be used to determine treatment progress and achievement of objectives.
8. Include assessment and treatment protocols for addressing each of the target behaviors.
9. Clearly identify the schedule of services planned and roles and responsibilities for service delivery.
10. Include frequent review of data on target behaviors.
11. Include adjustments of the treatment plan and/or protocols by the LBA as needed based upon the review of data, including recommendations for treatment intensity and duration based upon the member's response to treatment.
12. Include training, supervision, and evaluation of procedural fidelity for BCaBA®s, Behavior Analysis Trainees, and Behavior Technicians implementing treatment protocols.
13. Include training and support to enable parents and/or other caregivers, if applicable, to participate in treatment planning and treatment plan implementation.

14. Include care coordination activities involving the member's team in order to assist in the generalization and maintenance of treatment targets. This may include the Child and Family Team (CFT) or Adult Recovery Team (ART), Health Care Decision Maker, Primary Care Provider (PCP), school, medical specialists, behavioral health prescribers, DCS, and/or other state-funded programs, and others as applicable.
15. Result in progress reports at minimum, every six months. Progress reports shall include, but are not limited to, the following components:
  - a. Member Identification,
  - b. Background Information (family dynamics, school placement, cultural considerations, prenatal and/or developmental history, medical history, sensory, dietary and adaptive needs, sleep patterns, and medications),
  - c. Assessment Findings (i.e. social, motor, and self-help skills, maladaptive behaviors, and primary caregiver concerns),
  - d. Outcomes (measurable objectives, progress towards goals, clinical recommendations, treatment dosage, family role and family outcomes, and nature of family participation), and
  - e. Care Coordination (transition statement and individualized discharge criteria).
16. Be consistent with applicable professional standards and guidelines relating to the practice of behavior analysis as well as Arizona Medicaid laws and regulations and Arizona state Behavior Analyst licensure laws and regulations (A.R.S. §32-2091).

### **PROVIDER QUALIFICATIONS**

Behavior Analysis services shall be directed and overseen by Behavior Analysts and supported, where applicable, by Behavior Analysis Trainees and/or Behavior Technicians.

The Behavior Analyst is responsible for training Behavior Analysis Trainees and Behavior Technicians to implement assessment and intervention protocols with members. The Behavior Analyst is responsible for all aspects of clinical direction, supervision, and provider-level case management.

The Behavior Analyst shall be responsible for ensuring that the extent, kind, and quality of the Behavior Analysis Services the Behavior Analysis Trainee and Behavior Technician performs are consistent with his or her training and experience.

The Behavior Analyst shall be responsible for Behavior Analysis Trainee and Behavior Technician compliance with this Policy and Arizona state rules and regulations including those provisions set forth in A.R.S. §32-2091.

## BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

### **BEHAVIORAL HEALTH RESIDENTIAL TREATMENT FACILITY**

As Specified in A.A.C. R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that limits the individual's ability to be independent or causes the individual to require treatment to maintain or enhance independence.

#### **Admission Criteria**

1. Member has a diagnosed Behavioral Health Condition which reflects the symptoms and behaviors necessary for a request for residential treatment. The Behavioral Health Condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment by the following:
  - a. At least one area of significant risk of harm within the past three months as a result of:
    - i. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent,
    - ii. Impulsivity with poor judgment/insight,

- iii. Maladaptive physical or sexual behavior,
- iv. Member's inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports), or
- v. Medication side effects due to toxicity or contraindications.

**AND**

- b. At least one area of serious functional impairment as evidenced by:
  - i. Inability to complete developmentally appropriate self-care or self-regulation due to member's Behavioral Health Condition(s),
  - ii. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care,
  - iii. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders,
  - iv. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications, or
  - v. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem,
- c. A need for 24 hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community,
- d. Anticipated stabilization cannot be achieved in a less restrictive setting,
- e. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care, and
- f. Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

**Continuing Stay Criteria**

Continued stay shall be assessed by the BHRF staff and as applicable by the CFT/ART/TRBHA during Treatment Plan review and update. Progress towards the treatment goals and continued display of risk and functional impairment shall also be assessed. Treatment interventions, frequency, crisis/safety planning, and targeted discharge shall be adjusted accordingly to support the need for continued stay.

The following criteria shall be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a Behavioral Health Condition.
2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

**Discharge Criteria**

Discharge readiness shall be assessed by the BHRF staff and as applicable by the CFT/ART/TRBHA during each Treatment Plan review and update. The following criteria shall be considered when determining discharge readiness:

1. Symptom or behavior relief is reduced as evidenced by progress made or completion of Treatment Plan goals.

2. Functional capacity is improved; essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care.
3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care.
4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

### **Service Delivery**

- Evaluation and Treatment Planning
  - Except as provided in subsection R9-10-707(A)(9), a behavioral health assessment for a member is completed before treatment is initiated and within 48 hours of admission.
  - The CFT/ART/TRBHA is included in the development of the Treatment Plan within 48 hours of admission for members enrolled with a Contractor.
  - All BHRFs serving TRBHA members shall coordinate care with the TRBHAs throughout the admission, assessment, treatment, and discharge process.
  - The Treatment Plan connects back to the member's comprehensive Service Plan for members enrolled with a Contractor.
  - A comprehensive discharge plan is created during the development of the initial Treatment Plan and is reviewed and/or updated at each review thereafter. The discharge plan shall document the following:
    - Clinical status for discharge,
    - Member/guardian/designated representative and, CFT/ART/TRBHA understands follow-up treatment, crisis and safety plan, and
    - Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made).
  - The BHRF staff, Division support coordinator, Department of Children's Safety (DCS), any other agencies involved, and the CFT/ART/TRBHA meet to review and modify the Treatment Plan at least once a month.
  - A Treatment Plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours.
  - The provider has a system to document and report on timeliness of BHP signature/review when the Treatment Plan is completed by a BHT.
  - The provider has a process to actively engage family/guardians/designated representative in the treatment planning process as appropriate.
  - The provider's clinical practices, as applicable to services offered and population served, shall demonstrate adherence to best practices for treating specialized service needs, including but not limited to:
    - Cognitive/intellectual disability,
    - Cognitive disability with comorbid Behavioral Health Condition(s),
    - Older adults, and Co-Occurring disorders (substance use and Behavioral Health Condition(s), or
    - Comorbid physical and Behavioral Health Condition(s).
  - Services deemed medically necessary through the assessment and/or CFT/ART/TRBHA which are not offered at the BHRF, shall be documented in the Service Plan and documentation shall include a description of the need, identified goals and identified provider who will be meeting the need. The following services shall be made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:
    - Counseling and Therapy (group or individual):

- Note: Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified in the Service Plan as a specific member need that cannot otherwise be met as required within the BHRF setting,
  - Skills Training and Development:
    - Independent Living Skills (e.g. self-care, household management, budgeting, avoidance of exploitation/safety education and awareness),
    - Community Reintegration Skill building (e.g. use of public transportation system, understanding community resources and how to use them), and
    - Social Communication Skills (e.g. conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).
  - Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to:
    - Symptom management (e.g. including identification of early warning signs and crisis planning/use of crisis plan),
    - Health and wellness education (e.g. benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners),
    - Medication education and self-administration skills,
    - Relapse prevention,
    - Psychoeducation Services and Ongoing Support to Maintain Employment Work/Vocational skills, educational needs assessment and skill building,
    - Treatment for Substance Use Disorder (e.g. substance use counseling, groups), and
    - Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, R9-10-715, R9-10-814).
- Treatment outcomes shall align with:
  - The Arizona Vision-12 Principles for Children’s Behavioral Health Service Delivery as directed in AMPM Policy 430,
  - The 9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in Contract, and
  - The member’s individualized basic physical, behavioral, and developmentally appropriate needs.
- Treatment goals shall be developed in accordance with the following:
  - Specific to the member’s Behavioral Health Condition(s),
  - Measurable and Achievable,
  - Cannot be met in a less restrictive environment,
  - Based on the member’s unique needs and tailored to the member and the family’s/guardian’s/designated representative’s choices where possible, and
  - Support the member’s improved or sustained functioning and integration into the community.

## **Exclusions**

- An alternative to detention or incarceration.
- As a means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment.
- For the provision of providing safe housing, shelter, supervision, or permanency placement.
- A behavioral health intervention when other less restrictive alternatives are available and meet the member’s treatment needs, including situations when the member/guardian/designated representative are unwilling to participate in the less restrictive alternative, or
- As an intervention for runaway behaviors unrelated to a Behavioral Health Condition.

## HOME CARE TRAINING FAMILY (FAMILY SUPPORT)

Home Care Training Family (Family Support) support services are directed toward restoration, enhancement, or maintenance of the Family functioning to increase the Family's ability to effectively interact and care for the member in the home and community. Family support services may involve activities such as assisting the Family to adjust to the members illness, developing skills to effectively interact and/or guide the member, understanding the causes and treatment of behavioral health issues, and understanding and effectively utilizing the healthcare system. Refer to AMPM Policy 964 for training and credentialing standards for Credentialed Parent/Family Support individuals providing Parent/Family Support Services,

- Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. Support services shall be provided by individuals who are qualified Behavioral Health Professional (BHP) or Behavioral Health Technician (BHTs)/Behavioral Health Paraprofessional (BHPPs) supervised by BHPs.
- More than one provider agency may bill for family support provided to a member at the same time if indicated by the member's clinical needs as identified through their Service Plan.

### Admission Criteria

- Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer for children must:
  - Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance abuse needs; and
  - Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.
- Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer for adults must:
  - Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance abuse needs; and
  - Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.
- Home care training family services (family support) must be provided by certified behavioral health professionals, behavioral health technicians, or behavioral health para-professionals as defined by the following:
  - **Behavioral Health Professional:** An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    - Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    - Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in AAC. R4-6-101,
    - A psychiatrist as defined in A.R.S. §36-501,
    - A psychologist as defined in A.R.S. §32-2061,
    - A physician,
    - A behavior analyst as defined in A.R.S. §32-2091,
    - A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
    - A registered nurse with:
      - A psychiatric-mental health nursing certification, or
      - One year of experience providing behavioral health services

- **Behavioral Health Technician:** an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:
  - If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and
  - Are provided with clinical oversight by a behavioral health professional.
- **Behavioral Health Paraprofessional:** An individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:
  - If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S, Title 32, Chapter 33; and
  - Are provided under supervision by a behavioral health professional.
- Services are considered medically necessary regardless of a member's diagnosis, so long as there are documented behaviors and/or symptoms that will benefit from behavioral health services and a valid ICD-10-CM diagnostic code is utilized.

### **Service Delivery**

Family Support services include the following:

- Communication Techniques:
  - Person first, strengths-based language; using respectful communication; demonstrating care and commitment;
  - Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally;
  - Using self-disclosure effectively; sharing one's story when appropriate.
- System Knowledge:
  - Overview and history of the Arizona Behavioral Health System: Jason K., Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, Adult Recovery Team (ART), and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems,
  - Overview and history of the family and peer movements; the role of advocacy in systems transformation,
  - Rights of the caregiver/enrolled member
  - Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children's System of Care (CSOC) at transition for an enrolled member, family and Team.
- Building Collaborative Partnerships and Relationships:
  - Engagement; Identifies and utilizes strengths;
  - Utilize and model conflict resolution skills, and problem solving skills,
  - Understanding individual and family culture; biases; perceptions; system's cultures;
  - The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports;
- Empowerment
  - Empower family members and other supports to identify their needs, and promote self-reliance,
  - Identify and understand stages of change and
  - Be able to identify unmet needs.
- Wellness:



- Understanding the stages of grief and loss; and
- Understanding self-care and stress management;
- Understanding compassion fatigue, burnout, and trauma;
- Resiliency and recovery;
- Healthy personal and professional boundaries.

### **Billing Limitations**

- Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.
- Family support services provided in a DLS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. Please refer to the AHCCCS billing requirements.
- More than one provider agency may bill for home care training family services (family support) services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

## PROVIDER CASE MANAGEMENT

**Provider Case Management** is a supportive service provided to enhance treatment goals and effectiveness of treatment outcomes.

### **Admission Criteria**

- Assistance is needed in maintaining, monitoring and modifying covered services;
- Brief telephone or face-to-face interactions with a person, family or other involved party are needed for the purpose of maintaining or enhancing a person's functioning;
- Assistance is needed in finding necessary resources other than covered services to meet basic needs;
- Communication and coordination of care are needed with the person's family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies;
- Coordination of care activities are needed related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling);
- Outreach and follow-up of crisis contacts and missed appointments are needed;
- Staffings, case conferences or other meetings with or without the person or their family participating are required; and
- Other activities as needed.

### **Service Delivery**

- The responsible Provider Case Manager, in conjunction with the treatment team, completes an initial evaluation of the member's case management needs upon admission.
- The responsible Case Manager, in conjunction with the treatment team and, whenever possible, the member, develops a service plan that includes a description of the following:
  - The member's recovery and resiliency goals;
  - Strengths;
  - Problems;
  - Specific and measurable goals for each problem;
  - Interventions that will support the member in meeting the goals.
- The service plan may be informed by the findings of the initial clinical evaluation.
- With the member's permission, the Case Manager advocates for the member by sharing feedback about the member's experience with the treatment provider, as well as agencies or other programs with which the member is involved.

### **Limitations**

For case management services the following billing limitations apply:

- Case management services provided by a DLS licensed inpatient, residential or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility or day program can bill case management services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.
- A single provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously with any other services.
- Multiple provider agencies may bill for this service during the same time period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service (e.g., individuals involved in transitioning a person from a residential level of care to a higher (subacute) or lower (outpatient) level of care, staff from each setting may bill case management when attending a staffing).
- Billing for case management is limited to individual providers who are directly involved with service provision to the person (e.g., when a clinical team comprised of multiple providers, physicians, nurses etc. meet to discuss current case plans).
- Transportation provided to an AHCCCS BEHAVIORAL HEALTH SERVICES enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

#### THERAPEUTIC FOSTER CARE (FORMERLY HCTC)

**Therapeutic Foster Care (TFC)** services are delivered to children and youth whose behavioral health needs are of such a critical nature that in the absence of such services the child or youth would be at risk of transitioning into a more restrictive residential setting such as a hospital, psychiatric center, correctional facility, residential treatment program or a therapeutic group home.

Therapeutic Foster Care (TFC) services are provided by a behavioral health therapeutic home to a person residing in the TFC home in order to implement the in-home portion of the person's behavioral health service plan. TFC services assist and support a person in achieving their service plan goals and objectives. It also helps the person remain in the community setting, thereby avoiding residential, inpatient or institutional care. These services include supervision and the provision of behavioral health support services such as personal care (especially prescribed behavioral interventions), psychosocial rehabilitation, skills training and development, transportation of the person to therapy or visitations and/or the participation in treatment and discharge planning.

#### Admission Criteria

- In the absence of TFC the member is at risk of admission into a more restrictive setting such as a hospital, psychiatric center, correctional facility, residential treatment program or a therapeutic group home.
- Best practice is that the member is being serviced by a Child and Family Team (CFT).
- Efforts have been made by the CFT and Division support coordinator to provide services within the member's current home setting (e.g., biological, foster, adoptive, kinship).
- The CFT has recommended the need for 24 hour supervision in the TFC out of home treatment setting.
- The member is in need of TFC services that:
  - Provide basic parenting functions (e.g. food, clothing, shelter, educational support, meet medical needs, provide transportation, teach daily living skills, social skills, the development of community activities, and support spiritual/religious beliefs)
  - Provide therapeutic interventions (e.g. anger management, crisis de-escalation, psychosocial rehabilitation, living skills training and behavioral intervention) that will aid the child in making progress on Service Plan goals.
  - Provide a family environment that includes opportunities for:
    - Familial and social interactions and activities,

- Use of therapeutic interventions,
- Development of age appropriate living and self-sufficiency skills,
- Integration into a family and community-based setting,
- Documentation of progress toward goals.

### **Continuing Stay Criteria**

- The member's family/caregiver is involved in all aspects of the member's treatment.

### **Discharge Criteria**

- The continued stay criteria are no longer met. Examples include:
  - The member's condition no longer requires care.
  - The member's condition has changed to the extent that the condition now meets admission criteria for another level of care.
  - Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
  - The member requires medical/surgical treatment that precludes treatment in a mental health or substance use treatment setting
  - After an initial period of stabilization or motivational support, the member is unwilling or unable to participate in treatment despite motivational support or intervention to engage in treatment, and involuntary treatment or guardianship is not being pursued.

### **Clinical Best Practices**

#### **TFC provides the following services:**

- Meet the needs of the child/youth in their home as defined in the child's Service Plan. The TFC provider must be available to directly supervise the child/youth 24 hours per day, seven days a week for the entire duration that the child is receiving out of home treatment services.
- Receive ongoing training, supervision, and support, from the Professional Foster Care licensing agency and the behavioral health provider to ensure that professional foster homes delivering TFC services understand and commit to meeting each child's unique needs.
- Participate in planning processes such as CFTs, TFC discharge planning, Individualized Education Programs (IEPs), Team Decision Making, Juvenile Court hearings, and DCS Case Plan Staffing's.
- Keep documentation, per expectations of the Contractor or RBHA and licensing agency, of the child's behavior and progress toward specific outcomes as outlined in the Service Plan.
- Assist the child in maintaining contact with his/her family, including siblings in regular foster care and community settings, and work actively to enhance these relationships, unless contraindicated by the DCS case plan.
- Assist in meeting the child's permanency planning or TFC discharge planning goals.
- Advocate for the child in order to achieve goals within the Service Plan, obtain educational, vocational, medical, and other services needed to implement the plan, and ensure timely access to therapeutically indicated services and supports.
- At all possible times, the child's family and guardians should be included in all aspects of planning and treatment in accordance with legal requirements.
- When siblings require TFC services, the siblings should be served together unless precluded by safety, Juvenile Court orders, or other overriding clinical issues. If siblings must be placed separately, the Service Plan should provide opportunities that support, foster and encourage family ties through collaborative efforts between the respective professional foster home delivering TFC services, kinship or other caregivers by telephone, written and electronic communication, visitation arrangements, and social activities managed by the caregivers.
- TFC services should be delivered by a professional foster home most willing and able to meet the child's cultural and language needs.

- The child's past experiences with abuse, neglect, family and significant others, or environmental stressors can affect the child's success in treatment. The CFT needs to take into consideration the number, age, and gender of other children living in the professional foster family's home, other family members or adults who live in or frequent the professional foster family's home, and the likelihood that the makeup of the family will support the strengths and meet the needs of the child.
- Many children thrive in the presence of pets while others are fearful. Some children are aggressive towards vulnerable animals. The presence of pets in the professional foster home should be considered in the context of the safety of the child, the safety of the pets living in the home, and the professional foster home's willingness to accommodate the child's needs and desires relative to pets.
- The geographic location of the professional foster home delivering TFC services should be considered from multiple perspectives. The professional foster home's proximity to the child's current school and family home can affect the child's level of comfort, the accessibility of supportive and anchoring relationships, the reassurance that often accompanies familiarity, and the child's feelings of safety.
- Carefully assess the ability of the professional foster home to implement the Service Plan in the area in which they live, in proximity to the child's family, and in proximity to both positive and negative peer influences.
- The intensity of needs of every child and his/her presenting behavior challenges should be coordinated with the capabilities of the professional foster family's skills and experience.
- The medical needs of the child and the professional foster home's ability to respond to them on an ongoing basis and in crisis should be considered.
- Appropriate information is available from the professional foster home's OCLR home study that may provide additional information to the CFT about the professional foster home's ability to meet the individual needs of the child.
- If an acute hospital admission, arrest, or other occurrence (e.g. running away from the home providing TFC services) temporarily results in the child's removal from the professional foster home, the CFT should review the situation and implement appropriate interventions and services to ensure that the child can return to the same professional foster home if clinically appropriate.
- The event of a young person reaching his/her 18th birthday should not, by itself, require an end to needed and beneficial TFC service delivery. The CFT should address available options to continue TFC services prior to the child's 18th birthday.

## PRE-JOB TRAINING AND DEVELOPMENT

**Pre-Job Training and Development** are psychoeducational services and ongoing support to maintain employment services. These services are designed to assist a person or group to choose, acquire, and maintain a job or other meaningful community activity (e.g., volunteer work) services which prepare a person to engage in meaningful work-related activities may include but are not limited to the following: career/educational counseling, job shadowing, job training, including Work Adjustment Training (WAT); assistance in the use of educational resources necessary to obtain employment; attendance to Rehabilitation Services Administration (RSA)/Vocational Rehabilitation (VR) Information Sessions; attendance to Job Fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum, time management, and assistance in finding employment.

### Admission Criteria

- The member is in need of pre-job training and development in the following areas:
  - Career/educational counseling
  - Job shadowing
  - Assistance in the use of educational resources
  - Training in resume preparation
  - Job interview skills
  - Study skills

- Work activities
- Professional decorum and dress
- Time management
- Assistance in finding employment
- Job Training
- Work Adjustment Training (WAT)
- Attendance to RSA/VR Info Sessions
- Attendance to Job Fairs

## PEER AND RECOVERY SUPPORT

**Peer and Recovery Support Services** are a distinct health care practice involving intentional partnerships to provide social and personal support, based on shared experiences of living with mental health disorders, substance use disorders, and/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.

Peer Support services include the provision of assistance to more effectively utilize the service delivery system (e.g. assistance in developing plans of care, identifying needs, accessing supports, partnering with other practitioners, overcoming service barriers); or understanding and coping with the stressors of the individual's disability (e.g. support groups, coaching, role modeling and mentoring). These services may be provided to an individual, group, or family, and are aimed at assisting in the creation of skills to promote long-term, sustainable recovery. The Contractor shall ensure the provision of quality Peer Support services.

### Service Delivery

An individual trained, credentialed and qualified to provide peer/recovery support services within AHCCCS programs provide services to members according to the following core elements:

Concepts of Hope and Recovery:

1. Instilling the belief that recovery is real and possible,
2. The history of social empowerment movements, and their connection to Peer
3. and Recovery Support, including but not limited to:
  - a. Self-Help,
  - b. Consumer/Survivor/Ex-Patient,
  - c. Neurodiversity,
  - d. Disability Rights, and
  - e. Civil Rights.
4. Varied ways that Behavioral Health has been viewed and treated over time and in the present,
5. Appreciating diverse paradigms and perspectives of recovery and other ways of thinking about Behavioral Health (e.g. Harm Reduction, 12-Step Recovery, Neurodiversity),
6. Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways,
7. Holistic approach to recovery addressing behavioral, emotional, and physical health, and
8. Member-driven/Person-centered service planning.

Advocacy and Systems Perspective:

1. State and national health systems' infrastructure – the history of Arizona's health systems,
2. Confronting and countering discrimination, prejudice, bias, negative stereotypes and other social injustices against those with behavioral health and substance use disorders – combating internalized stigma and oppression,
3. Organizational change – how to utilize person-first and identity-first language to educate provider staff on recovery principles and the role and value of Peer Support,
4. Creating a sense of community in a safe and supportive environment,

5. Forms of advocacy and effective strategies – consumer rights and navigating health systems, and
6. The Americans with Disabilities Act, (ADA).

Psychiatric Rehabilitation Skills and Service Delivery:

1. Strengths based approach, identifying one’s own strengths and helping others identify theirs, building resilience,
2. Trauma-Informed Care
3. Distinguishing between sympathy and empathy emotional intelligence,
4. Understanding learned helplessness, how it is taught and how to assist others in overcoming it’s effects,
5. Motivational interviewing, communication skills and active listening,
6. Healing relationships – building trust and creating mutual responsibility,
7. Combating negative self-talk – noticing patterns and replacing negative statements about one’s self, using mindfulness to gain self-confidence and relieve stress,
8. Group facilitation skills, and
9. Culturally & Linguistically Appropriate Services (CLAS) standards, and the role of culture in recovery.

Professional Responsibilities of the PRSS and Self Care in the Workplace:

1. Professional boundaries and codes of ethics unique to the role of a PRSS,
2. Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA) responsibilities of a mandatory reporter, what to report and when,
3. Understanding common signs and experiences of:
  - a. Mental health disorders,
  - b. Substance Use Disorders (SUD),
  - c. Opioid Use Disorder (OUD),
  - d. Addiction,
  - e. Dissociation,
  - f. Trauma, and
  - g. Abuse/exploitation and neglect
4. Familiarity with commonly used medications and potential side effects Informed Consent (Refer to AMPM Policy 320-Q)
5. Guidance on proper service documentation, billing and using recovery language throughout documentation.
6. Self-care skills:
  - a. Coping practices for helping professionals,
  - b. The importance of ongoing supports for overcoming stress in the workplace,
  - c. Using boundaries to promote personal and professional resilience, and
7. Preventing burnout using self-awareness to prevent compassion fatigue, vicarious trauma, and secondary traumatic stress.

## SKILLS TRAINING AND DEVELOPMENT

**Skills Training and Development** involves teaching independent living, social, and communication skills to persons and/or their families in order to maximize the person’s ability to live and participate in the community and to function independently. Examples of areas that may be addressed include self-care, household management, social decorum, same- and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources. Services may be provided to a person, a group of individuals or their families with the person(s) present.

**Admission Criteria**

- The member is in need of training and development in the following areas:
  - Self-care

- Household management
- Social decorum
- Same- and opposite-sex friendships
- Avoidance of exploitation
- Budgeting
- Recreation
- Development of social
- Support networks

## UNSKILLED RESPITE

**Unskilled Respite** means short term behavioral health services or general supervision that provides rest or relief to a family member or other individual caring for the behavioral health recipient. Respite services are designed to provide an interval of rest and/or relief to the family and/or primary care givers and may include a range of activities to meet the social, emotional and physical needs of the behavioral health recipient during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays.

Respite services can be planned or unplanned. If unplanned respite is needed, agency personnel will assess the situation with the caregiver and recommend the appropriate setting for respite.

### Admission Criteria

- The member's condition indicates that the member's family or caregiver requires a temporary break from caregiving. Examples include:
  - The stress of caregiving has put the member at imminent risk of abuse or neglect.
  - Other responsibilities temporarily prevent the member's family or caregiver from assisting the member with Activities of Daily Living (ADLs).

### Service Delivery

- See Common Clinical Best Practices.
- The responsible provider evaluates the member and caregiver's need upon admission.
- The responsible provider, in conjunction with the member and/or member's family or caregiver, develops a service plan that includes the following:
  - The goal(s) of Respite Care;
  - Specific, measurable objectives aimed at achieving the goal(s) of Respite Care.
  - The service plan incorporates instructions for medical care, special needs and emergencies.
  - The service plan also addresses the need for other services and resources that become apparent during the provision of Respite Care. As needed, the provider assists the member with accessing other services and resources.
- The service plan may be informed by the findings of the initial clinical evaluation.
- The provider ensures that necessary medication, medical equipment, and assistive technology accompany the member when Respite Care is provided at a site other than the member's residence.

## REFERENCES

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#### REVISION HISTORY

| Date    | Action/Description  |
|---------|---|
| 8/2019  | • Version 1   |
| 12/2019 | • Version 1 revised                                       |
| 4/2020  | • Version 2   |
| 6/2021  | • Version 2 Annual Review; Approved by healthplan 8/25/21 |