County of Sacramento **Department of Health and Human Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-10-26**
	Effective Date	**07-01-2014**
	Revision Date	**07-01-2023**

Title: **CalAIM Assessment (Mental Health)**	Functional Area: **Chart Review - Non-Hospital Services**

Approved By: (Signature on File) **Signed version available upon request**

Alexandra Rechs, LMFT
Program Manager, Quality Management

BACKGROUND/CONTEXT:

The CalAIM Assessment is the assessment used by Sacramento County Division of Behavioral Health Services and the Mental Health Plan (MHP) providers utilizing SmartCare electronic health record. Providers with their own Electronic Health Record (EHR) utilize an equivalent vetted Assessment Document which contains all of the same required elements. The CalAIM Assessment shall include the provider's determination of medical necessity and recommendation for services. The Assessment details important information and history related to the member's reasons for service, psychosocial history, problem and risk areas, and other key areas of member functioning and history. The Department of Health Care Services (DHCS) requires practitioners to complete an assessment for the determination of behavioral health needs. Under CalAIM, providers are required to use DHCS identified uniform assessment domains and for beneficiaries under age 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool is required to be utilized and should inform the assessment. (See QM P&P 01-07 Determination for Medical Necessity and Access to Specialty Mental Health Services, QM 10-31 Child and Adolescent Needs and Strengths and DHCS Behavioral Health Information Notice (BHIN) 17-052 Performance Outcome System Functional Assessment Tools).

PURPOSE:

The purpose of the CalAIM Assessment, capturing the standardized Seven Domains, is to understand the person's needs and circumstances, in order to recommend the best care possible and to help the person recover. The assessment must be completed under the guidance of an LPHA. The assessment evaluates the person's mental health and well-being and explores the current state of the person's mental, emotional, and behavioral health and their ability to thrive in their community. An assessment may require more than one session to complete. It may also require the practitioner to obtain information from other relevant sources, referred to as "collateral information", such as previous health records or information from the person's support system. This is done in order to gather a cohesive understanding of the person's care needs. Other assessment forms may be required as applicable to program requirements.

The purpose of this policy is to establish guidelines, requirements, and timelines for completion of the CalAIM Assessment. The policy provides clinical guidelines for completion of the CalAIM Assessment. It is not a substitute for technical training in use of the SmartCare EHR. This policy is applicable to providers with their own EHR Assessment Documents as well.

DEFINITIONS:

Clinical Bundle: The required documentation to be completed by the assigned provider including assessment Documents, problem list and if applicable, care plan. Refer to QM Documentation Training: Documentation Bundles and your contract for the specific required documentation.

CalAIM Assessment 7 Domains: The assessment contains universally-required domains that should not vary from MHP to MHP or Agency to Agency. Below is information on the standardized domains comprising the assessment for understanding the person's care needs. While each of the domains are required and must be addressed, information may overlap across domains. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure a clear and ideally chronological account of the person's current and historical need is accurately documented. Include the perspective of the person being assessed and, whenever possible, use their quotes within the document.

Enrollment Date: The date that the member is assigned to the Mental Health Plan (MHP) or Drug Medi- Cal Organized Delivery System (DMC-ODS) provider.

DETAILS:

It is the policy of Sacramento County MHP that a CalAIM Assessment be completed for all beneficiaries.

1. CalAIM Assessment: The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice. Sacramento County considers it best practice to complete the assessment within 90 days, unless there is documentation of any issues (i.e., acuity, homelessness, difficulty with engagement) that prove to be a barrier to completion. Assessments not completed during these timelines will not result in recoupments.

2. Updates to the CalAIM Assessment can be documented in a progress note and include any items of clinical significance. The Assessment billing code should be used and the Problem List updated for monitoring and tracking purposes.

3. To the extent the information is available, all components listed within each of the seven domains shall be included as part of a comprehensive assessment.

4. Staff qualified to complete the CalAIM Assessment are LPHA, LPHA Waived or Students. If a Student who is not licensed or licensed waived is contributing to the assessment, this shall be done in collaboration with, direction by, and with oversight of the LPHA who is responsible for the completion and co-signing of that CalAIM Assessment. Staff who are not licensed or licensed waived may contribute to the assessment by gathering the following information within the service note: the member's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (See Staff Registration P&P).

5. CalAIM Assessments are not considered complete unless they are signed; and co-signed, if required and saved.

6. Beneficiaries transferred within the Sacramento County MHP require a new CalAIM Assessment within 60 days, or as clinically appropriate, from the date of transfer. Transferring providers should coordinate with the new provider to provide successful linkage, coordination of care, and transfer of assessment information.

7. A CalAIM Assessment Report format must be used when a printed "hardcopy" form or PDF "softcopy" of the document is needed from the EHR. "Screen shots" of CalAIM Assessment data entry screens are not acceptable and may include restricted member information that

cannot be legally shared or viewed. Providers with their own EHR should ensure that printed reports do not contain restricted member information.

8. Items identified in the DHCS BHIN 22-019 are required and must be completed. Providers using their own EHR must include the information required in the Seven Domains in their assessment template.

9. A diagnosis from the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a corresponding Department of Health Care Services (DHCS) approved ICD-10 code must be documented in the Diagnosis Document (Client). This diagnosis must be consistent with the presenting problems and mental status exam.

10. The Problem List section must accurately reflect a list of relevant symptoms, conditions, diagnoses, and/or risk factors identified through the assessment. This should reflect the member's care needs that is also inclusive of key health and social issues.

11. Crisis assessments completed during the provision of SMHS crisis intervention or crisis stabilization are not required to include all of the seven domains and components. However, crisis assessments are not a replacement for a full SMHS domains assessment. When a member who has received crisis intervention or crisis stabilization subsequently receives other SMHS, an assessment shall be completed.

PROCEDURE:

The CalAIM Assessment may include the following information based on the CalAIM Seven Domains (See CalMHSA_MHP_LPHA_Documentation Guide [pages 12-15] for domain categories, key elements, and guidance on information to consider under each domain). Note that all domains and subdomains must be assessed and captured within the CalAIM Assessment:

Domain 1:

Requirements:	Description:
• Presenting Problem(s) • Current Mental Status • History of Presenting Problem(s) • Member-Identified Impairment(s)	Chief complaint • Member-identified problem(s), history of the presenting problem(s), impact of problem(s) on member • Member's mental state at the time of the assessment • Impairment identified by the member including distress, disability, or dysfunction in an important area of life function

***The MSE is completed by licensed or licensed waived staff. A staff that is not licensed or licensed waived may contribute to the MSE by documenting their observations. This would be done in collaboration with, direction by, and oversight of the LPHA who is responsible for the completion of the MSE within the CalAIM Assessment.**

Domain 2:

Requirements:	Description:
• Trauma	History of trauma or exposure to trauma: • Any psychological, emotional response to an event that is deeply distressing or disturbing • A reaction to stressful situations and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk factors • A measure of trauma indicating elevated risk for

	development of a mental health condition • Experience with homelessness, juvenile justice involvement, or involvement in the child welfare system

Domain 3:

Requirements:	Description:
• Behavioral Health History • Comorbidity	Mental Health History: • Acute and chronic conditions • Previous community-based treatment, including providers, therapeutic modality (e.g., medications, therapy, rehabilitative interventions, etc.) and response to interventions • Inpatient admissions • Crisis-based admissions or encounters Substance Use History: • Exposure/substance use, including past and present use (e.g., substance of choice/ type, method, and frequency of use.) • Previous community-based treatment, including providers, therapeutic modality (e.g., medication-assisted treatment, rehabilitative interventions, etc.) and response to interventions • Inpatient psychiatric admissions • Intoxication/detox/withdrawal management-based admissions

Domain 4:

Requirements:	Description:
• Medical History • Current Medications • Comorbidity with Behavioral Health	Medical History: • Relevant current or past physical health conditions • Information on help seeking for physical health treatment • Prenatal and perinatal events, and relevant or significant developmental history • History of medications, medical treatments, reason for medication usage and responses. If a member has not been prescribed medication or is not interested in medication support, then this would be documented in this domain. • Allergies to medications • When current health concerns are evident, the provider refers the member to a Primary Health Care Provider or the attending Psychiatrist for physical evaluation and documents the details of this referral in the Progress Notes.

Domain 5:

Requirements:	Description:
• Social and Life Circumstances • Culture/Religion/Spirituality	• Psychosocial factors: • Living situation, daily activities, social support, and cultural and linguistic factors • Community engagement • Legal or justice-involved history • Family history and current family involvement • Military history • Tribal affiliation • LGBTQ+ • BIPOC • Gender identifications • Spiritual and/or religious beliefs, values and practices

Domain 6:

Requirements:	Description:
• Strengths • Risk Behaviors • Safety Factors	Strengths, risk behaviors and safety factors: • Strengths in achieving goals, including personal motivation, drive, hobbies and interests. • Resilience and coping skills • Protective Factors, including the availability of resources, opportunities, and supports (including support persons), interpersonal relationships, systems (family/community/ professional), activities (routines/ social hobbies/ etc.) • Situations and triggers that may induce risky behaviors • Suicidal/homicidal ideation • Safety planning, including an individualized plan that can be self-initiated or initiated by a trusted person (e.g. sponsor)*

***The Risk Assessment completed in Domain #6 should inform the use of the Safety Plan/Crisis Plan**

Domain 7:

Requirements:	Description:
• Clinical Summary and Recommendations • Diagnostic Impression • Medical Necessity Determination • Level of Care/Access Criteria	Clinical impression, including etiology, clinical complexity, and impairments: • Predisposing, precipitating, perpetuating and protective factors to inform the problem list • Diagnosis/ICD-code consistent with presenting problems, history, mental status exam and/or other clinical data, including any current medical diagnosis. Capture diagnostic uncertainty (provisional or unspecified) • Service recommendations for the treatment episode

Providers may use the following options during the assessment phase of a member's treatment when a diagnosis has yet to be established:

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and

psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a member's treatment when a diagnosis has yet to be established.

- In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS approved ICD-10 diagnosis code list 1, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services.

SmartCare Specific Guidance:

Note: Click "Save" and "Sign" to complete and generate the document. Once signed the date of signature will reflect on the document.

REFERENCE(S)/ATTACHMENTS:

- Attachment 1 - Documentation Matrix
- Attachment 2 - Staff Billing Privileges Matrix
- Mental Health Plan Contract
- California Code of Federal Regulations, Title 9, Chapter 11, Section § 1810.204. Assessment
- MHSUDS IN# 17-040
- BHIN# 22-019
- CalMHSA MHP-LPHA Documentation Manual 06-2022

RELATED POLICIES:

- QM 10-27 Client Plan
- QM 01-07 Determination for Medical Necessity & Access To Specialty Mental Health Services

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	X	Children's Contract Providers
X	Mental Health Treatment Center	X	Substance Use Prevention and Treatment
X	Adult Contract Providers	X	Specific grant/specialty resource

CONTACT INFORMATION:

- Quality Management Information
  QMInformation@saccounty.gov