Best Practices Assessment Checklist

- Providers are required to utilize the 7 Domains.
- Begin by assessing safety and risk, then prioritize other urgent needs.
- For Children/Youth (ages 6 and up to the age of 21), the CANS may be used to inform the assessment. For Children/Youth (ages 3 and up to the age 18) the PSC-35 may be used to inform the assessment.
- For Adults (ages 21+), the ANSA may be used to inform the assessment.
- The *Initial CalAIM Assessment* shall be finalized within 90 days of the assignment to the provider, unless there are documentation of any issues that prove to be a barrier to completion (i.e., acuity, homelessness, difficulty with engagement).
- The *Updated Assessment* shall be completed within the staff's clinical discretion (reasonable and within accordance with generally accepted standards of practice). This may be completed in a Progress Note.
- The services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether access criteria is met are covered and reimbursable, even if the assessment ultimately indicates that the person does not meet criteria for Specialty Mental Health Services (SMHS).
- Include a typed or legibly printed name, staff signature, date of signature, and co-signature/date of co-signature (if applicable).
- Document the provider's recommendation & determination for medical necessity for services.
- 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.
- The diagnosis, mental status exam, medication history & assessment of relevant conditions and psychosocial factors affecting the person's physical and mental health must be completed by a provider, operating in their scope of practice under California State law, who is licensed, registered, waivered and/or under the direction of a licensed mental health professional as defined in the State Plan.
- Other qualified staff (within their scope of practice) may be designated to contribute to the gathering assessment information within the service note including details about the person's mental health/medical history, substance exposure/use, and identifying strengths, risks, and barriers to achieving goals.

The 7 Domains

Initial Assessment shall be documented within the CalAIM Assessment unless otherwise indicated.
Updated Assessment may be completed within a Progress Note.

☐ **Domain #1 – Presenting Problem/Chief Complaint:**

- Presenting Problem (Current and History of) - Specific details about the current problem(s), history of problem(s), and impact of problem(s). Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.
- Current Mental Status Exam - Mental state at the time of the assessment.
- Impairments in Functioning - Level of distress, disability, or dysfunction in one or more important areas of life functioning including protective factors related to functioning.

☐ **Domain #2 – Trauma:**

- Trauma Exposures - Psychological, emotional responses, and symptoms related to one or more life events that are deeply distressing or disturbing.
- Trauma Reactions - Reaction to stressful situations and/or information on the impact of trauma exposure/history to well-being, developmental progression, and/or risk behaviors.
- Trauma Screening - Results of the trauma-screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACEs}) indicating elevated risk for development of a mental health condition. ←Pending DHCS approval.
- Systems Involvement - Experience with homelessness, the juvenile justice system, or child welfare system.

☐ **Domain #3 – Behavioral Health History:**

- Mental Health History - Acute or chronic conditions not earlier described including previously diagnosed or suspected mental health conditions.
- Substance Use/Abuse - Past/present use of substances, including type, method, and frequency of use including previously diagnosed or suspected substance use conditions.
- Previous Services - Previous treatment received for mental health and/or substance use concerns, including providers, therapeutic modality, length of treatment, and efficacy/response to interventions.

☐ **Domain #4 – Medical History and Medications:**

- Physical Health Conditions - Relevant current or past medical conditions, including treatment history, information on help seeking for physical health treatment, allergies (including those to medications) should be clearly and prominently noted.
- Current Medications - Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, efficacy/benefits, and if available, start/end dates or approximate timeframe.
- Developmental History - Prenatal/perinatal events and relevant or significant developmental history, if known and available (primarily for persons aged 21 or younger)
- Co-occurring Conditions (other than substance use)-

☐ **Domain #5 – Psychosocial Factors:**

- Family - Family history, current family involvement, significant life events within family.
- Social and Life Circumstances - Current living situation, daily activities, social supports/networks, legal/justice involvement, military history, community engagement, interactions with others/relationship with their community.
- Culture/Religion/Spirituality - Cultural/linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other (LGBTQ+) or Black, Indigenous, and People of Color (BIPOC) identities, gender identifications, spirituality and/or religious beliefs, values, and practices

☐ **Domain #6 – Strengths, Risks and Protective Factors:**

- Strengths and Protective Factors - Personal motivations, desires/drives, hobbies/interests, positive savoring/coping skills, availability of resources, opportunities/supports, interpersonal relationships.
- Risk Factors and Behaviors - Suicidal ideation/planning/intent, homicidal ideation/planning intent, aggression, inability to care for self, recklessness, etc. Includes triggers/situations that may result in risk behaviors, history of previous attempts, family history of/involvement in risks, context for risk behaviors, willingness to seek/obtain help. May include specific risk screening/assessment tools and the associated results.
- Safety Planning - Specific safety plans to be used should risk behaviors arise including actions to take and trusted individuals to call during crisis. This may be documented within the Safety Crisis Plan form.

☐ **Domain #7 – Clinical Summary, Treatment Recommendations, Level of Care Determination:**

- Clinical Impression/Medical Necessity Determination/LOC/Access Criteria - Summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problems), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating, and/or perpetuating factors to inform the problem list.
- Diagnostic Impression - Clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified)
- Treatment Recommendations – Recommendations for detailed and specific interventions and service types based on clinical impression, and overall goals for care.