Monterey County Behavioral Health Quality Improvement CalAIM Implementation Memo: 003

Re:	Documentation Reform: CalAIM Assessment (Specialty Mental Health Services)
Form Reference	Behavioral Health Information Notice No.: 22-019: Documentation requirements for all Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services Additional reference: Behavioral Health Information Notice No.: 21-073: Criteria for Beneficiary Access to Specialty Mental Health Services (SMHS), Medical Necessity and Other Behavioral Health Information Notice No.: 22-013: Coverage Requirements Code selection during assessment period for outpatient behavioral health (BH) services
Effective	7/22/2022

Topic

In the spirit of California Advancing and Innovating Medi-Cal (CalAIM), Monterey County Behavioral Health (MCBH) is moving forward with implementing the new documentation requirements for the Universal Psychosocial Assessment for Specialty Mental Health Services (SMHS). These new documentation requirements were established by the Department of Health Care Services (DHCS).

The goal of an assessment is to understand the person's needs and circumstances, in order to recommend the best care possible and help the person recover. 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.

Procedure

1. **Effective 7/22/2022**.
2. The Universal Psychosocial Assessment form will be retired and the new **CalAIM Assessment** will be made available and shall be used starting 7/22/2022.
    a. The Universal Psychosocial Assessment form will no longer be available after 7/21/2022.
    b. Staff will have until 9/30/2022 to finalize any existing Universal Psychosocial Assessment.
    c. The 138 Professional Psychosocial report will continue to be available for the Universal Psychosocial Assessment and the new CalAIM Assessment.
3. Completing the CalAIM Assessment:
    a. For existing beneficiaries
        i. The case coordinator shall be responsible for the completion of an updated CalAIM Assessment at the time of the annual renewal effective 7/22/2022.
    b. For new beneficiaries
        i. The case coordinator shall be responsible for the completion of an initial CalAIM Assessment effective 7/22/2022.
    c. The time period for clinicians to complete an initial assessment and updated 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.

4. MCBH is required to use the uniform assessment domains as identified below. Elements of the CalAIM Assessment include:
    a. **Domain 1: Presenting Problem/Chief Complaint**
        i. Current mental status.
        ii. Presenting Problem(s): current and history of presenting problem and impact of the problem and when possible cultural understanding of problem, duration, and severity.
        iii. Impairments in Functioning: level of distress, disability, or dysfunction in 1+ important areas of life functioning.
    b. **Domain 2: Trauma**
        i. Trauma Exposures: life event(s) that is/are deeply distressing or disturbing.
        ii. Trauma Reactions: such as psychological, emotional responses, symptoms and impact to well-being, developmental progression, and/or risk behaviors.
        iii. Trauma Screening: tool results such as ACEs
        iv. Systems Involvement: homelessness, juvenile justice, or child welfare (if applicable).
    c. **Domain 3: Behavioral Health History**
        i. Previous/current mental health acute or chronic conditions not mentioned in Presenting Problem.
        ii. If available, previous/current mental health treatment: providers, modality, length of treatment, and response to interventions.
        iii. Previous/current substance use including type, method, and frequency of use.
        iv. Substance use conditions previously diagnosed or suspected.
        v. If available, previous/current substance use treatment: providers, modality, length of treatment, and response to interventions including withdrawal and Medication Assisted Treatment (MAT).
    d. **Domain 4: Medical History and Medications**
        i. Physical Health Conditions: previous and current medical conditions and treatment (i.e. providers, modality, length of treatment, and response to interventions).
        ii. Current and Past Medications: including prescribing doctor, reason for usage, dosage, frequency, adherence, efficacy, and when available, start/end dates.
        iii. Development History: prenatal and perinatal events (21-years & younger).
        iv. Allergies.
    e. **Domain 5: Psychosocial Factors**
        i. Family: current family involvement (i.e. single, estranged, widowed, loss, birth, etc.).
        ii. Social and Life Circumstances: current living situation and interaction with others and larger community (i.e. daily activities, social supports, etc.).
        iii. Cultural Considerations: such as cultural/linguistic factors, LGBTQ+ and BIPOC identities, and spirituality and/or religious beliefs, values, or practices.
    f. **Domain 6: Strengths, Risk and Protective Factors**
        i. Strengths and Protective Factors: such as personal motivations, desires, hobbies, coping skills, etc.
        ii. Risk Factors and Behaviors: such as SI, HI, GD, impulsivity, aggression, etc.
        iii. Safety Planning: specific safety plans to be used should risk behaviors arise.
    g. **Domain 7: Clinical Summary, Treatment Recommendations, Level of Care Determination**

i. Clinical Impression: including summary of symptoms supporting the diagnosis and impairments connected to presenting problem and hypothesis regarding factors to inform problem list.
ii. Diagnostic Impression: diagnoses and/or diagnostic uncertainties (rule-outs, provisional, or unspecified).
iii. Diagnosis is consistent with symptoms and impairments documented in the assessment.
iv. Treatment Recommendations: detailed and specific interventions and service types and overall goals for care.

h. **Additional Requirements**:
   i. Mental Status Exam form: the Mental Status Exam form is required as part of the assessment and may be utilized to help inform the assessment domain requirements. This shall be completed as part of the initial assessment and completed annually thereafter.
   ii. ACE form: the ACE form is required as part of the assessment and may be utilized to help inform the assessment domain requirements, particularly in Domain 2: Trauma. This shall be completed at least once as part of the initial assessment and updated as needed. (Note: some CSOC programs may be required to use the Pediatric Early Adversity and Related Life Effect Screen).
   iii. For Children:
      1. CANS 50: For persons in care under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool is required as part of the assessment may be utilized to help inform the assessment domain requirements. The CANS must be completed as part of the initial assessment, updated every 6 months, and at the time of discharge.
      2. PSC- 35: for persons in care ages 3 up to18, the Pediatric Symptom Checklist (PSC-35) must be completed as part of the initial assessment, updated every 6 months, and at the time of discharge and may be utilized to help inform the assessment domain requirements.
   iv. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether Non-SMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the person does not meet criteria for SMHS.
      1. An appropriate ICD-10 diagnosis code is required to submit claims to receive reimbursement; this includes ICD-10 codes Z55-Z65, Z03.89, and other codes due to a suspected disorder that has not yet been diagnosed such as “Other specified” and “Unspecified” disorders,” or “Factors influencing health status and contact with health services.”
   v. The assessment shall include the provider’s recommendation and determination of medical necessity for services. The problem list and progress note requirements shall support the medical necessity of each service provided.
   vi. The diagnosis, Mental Status Exam (MSE), medication history, and 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.