PLEASE CLICK THE SURVEY MONKEY LINK IN THE CHAT TO TAKE A QUICK THREE-QUESTION SURVEY

STANDARDIZING DOCUMENTATION: UNIVERSAL ASSESSMENT

California Mental Health Services Authority (CalMHSA)

May 25, 2022

CALMHSA INTRODUCTIONS

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TRAINING OBJECTIVES

Participants will walk away with:

- A comprehensive understanding of new standardized assessment requirements for Specialty Mental Health Services (SMHS) and a review of DMC/DMC-ODS assessment requirements.

- Clarity regarding what is expected of each of the seven assessment domains.

WE ARE HERE

TRANSFORMATION WEBINARS: FOR COUNTY LEADERSHIP & COUNTY QI STAFF

Welcome to CalAIM: Then vs. Now	04/27/22
Shifting our Focus: Compliance vs. Quality	05/04/22
Communication Plans: Change Messaging	05/11/22
Initiating Treatment: No Wrong Door/Treatment Prior to Diagnosis	05/18/22
Standardizing Documentation: Universal Assessment	05/25/22
Identifying Treatment Focus: Problem List	06/01/22
Documenting Care: Progress Notes	06/08/22
No Money, No Mission: Billable vs. Non-Billable Services	06/15/22
Outcomes That Matter: Quality Measurement	06/22/22
You've Got This: CalAIM – A Summary	06/29/22

STANDARDIZED ASSESSMENTS

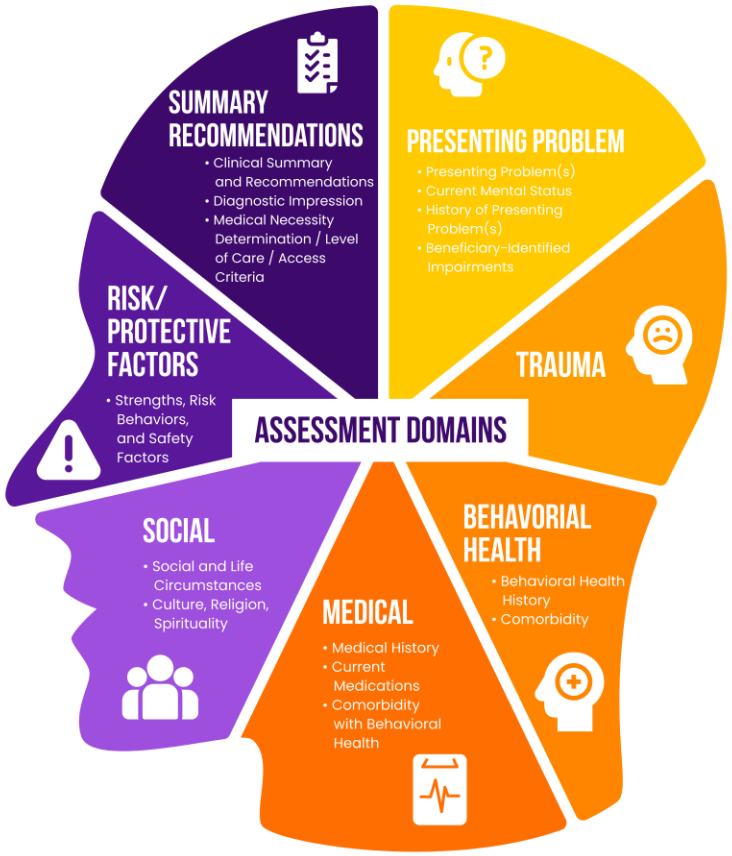
POSITIVE IMPACTS OF ASSESSMENT STANDARDIZATION

WHAT IS THE ORIGIN OF MOVING TO A STANDARDIZED ASSESSMENT?

Special Guest:

Michelle Doty Cabrera

Executive Director, CBHDA



WHAT IS THE GOAL OF THE STANDARDIZED ASSESSMENT?

To understand the person's needs and circumstances, in order to recommend the best care possible and help the person recover

ASSESSMENTS: AN IMPORTANT RELATIONSHIP BUILDING OPPORTUNITY

- Focusing on strengths, culture, and resiliency, in addition to challenges, creates a setting where the person in care feels seen as a whole person.
- Assessments must be approached with the knowledge that one's own perspective is full of assumptions, so that clinicians maintain an open mind and respectful stance towards the person in care.
- A key outcome of the assessment process is the generation of shared agreement on the strengths and needs of the person in care, as well as how to best address those needs.
- The assessment process generates a hypothesis, developed in collaboration with the person in care, that helps to organize and clarify service planning.

STANDARDIZED ASSESSMENTS & INTEROPERABILITY

To best help the humans we serve, modern healthcare standards involve the sharing of information across care providers.

The new standardized assessment will allow for assessments to be shared, with consent, with other care providers.

In sharing the assessment between behavioral health and physical health providers we can reduce duplication and ensure all treating providers have the necessary information to best help the people we serve.

STANDARDIZED ASSESSMENTS FOR SMHS – WHAT ARE THE REQUIREMENTS?

- Assessments for mental health services for adults aged 21 years and older shall cover all the domains listed in the section below.

- Assessment for mental health services for persons under the age of 21 years old shall include the Children and Adolescent Needs and Strengths (CANS-50) and Pediatric Symptom Checklist (PSC-35) in addition to the domains listed in the section below.

STANDARDIZED ASSESSMENTS FOR SMHS (CONTINUED)

- Remember: Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the beneficiary does not meet criteria for SMHS.

- The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.

- The assessment shall include the provider's recommendation – and determination of medical necessity for services.

WHO CAN COMPLETE AN ASSESSMENT FOR SMHS?

- The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the beneficiary's physical and mental health must be completed by a provider, operating in his/her scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional (LMHP) as defined in the State Plan.

- MHPs may designate certain other qualified providers to contribute to the assessment, including gathering the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals.(Cal. Code Regs., tit. 9, § 1840.344; California State Plan, Sec. 3, Att. 3.1-A, Supp. 3, pp. 2m-p; California State Plan Section 3, Att.3.1-B, Supp. 2, pp. 15-17)

SMHS ASSESSMENT TIMELINESS GUIDELINES

The time period for MHPs to complete an initial assessment and subsequent assessments is up to clinical discretion (reasonable and in accordance with generally accepted standards of practice)

DMC/DMC-ODS ASSESSMENT REQUIREMENTS

The required 7 assessment domains do not apply to DMC/DMC-ODS services

DMC/DMC-ODS providers are required to use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC and DMC-ODS beneficiaries

CALAIM ASSESSMENT REQUIREMENTS FOR DMC AND DMC-ODS

CalAIM does not change requirements for assessments within substance use services. Providers are required to use the ASAM Multi-Dimensional Assessment to determine the appropriate level of care to meet the client's needs.

ASAM uses six standardized dimensions that must be included in all DMC and DMC-ODS assessments:

- **Dimension 1 – Acute Intoxication and/or Withdrawal Potential**
- **Dimension 2 – Biomedical Conditions and Complications**
- **Dimension 3 – Emotional, Behavioral or Cognitive Conditions and Complications**
- **Dimension 4 – Readiness to Change**
- **Dimension 5 – Relapse, Continued Use or Continued Problem Potential**
- **Dimension 6 – Recovery/Living Environment**

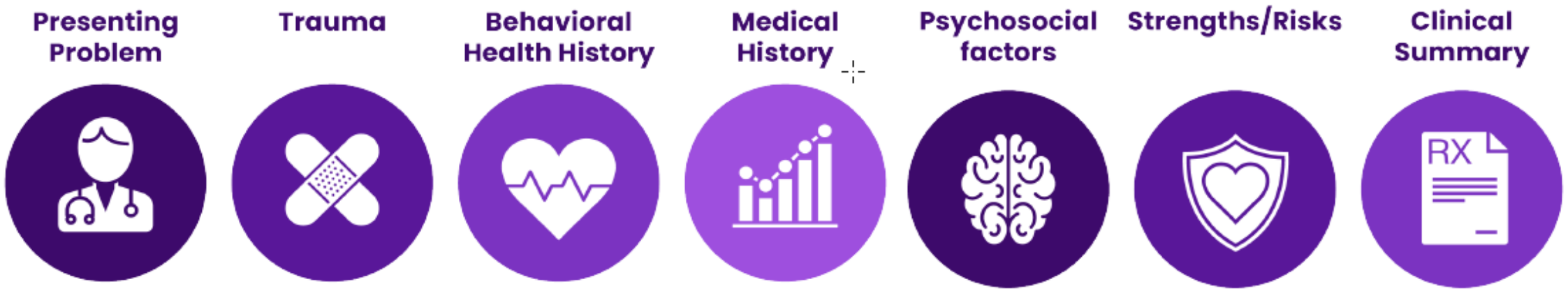
Specific information about the ASAM assessment can be found at https://www.asam.org

STANDARDIZED ASSESSMENTS – PERSON CENTERED & REDUCES BURDEN

Standardized Assessment Domains- Deep Dive

(Applies to MHPs)

Assessment Domains – At a Glance



DOMAIN 1

PRESENTING PROBLEM/CHIEF COMPLAINT

Focuses on the main reason the person is seeking care, in their own words if appropriate. The goal is to document an account of what led up to seeking care. This domain addresses both their current and historical states related to the chief complaint

Presenting Problem (Current and History of) –The person's and collateral sources' descriptions of problem(s), history of the presenting problem(s), impact of problem on person in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact

Current Mental Status Exam (MSE) – The person's mental state at the time of the assessment

Impairments in Functioning – The person and collateral sources identify the impact/impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning

DOMAIN 2

TRAUMA

Involves information on traumatic incidents, the person in care's reactions to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. Take your cues from the person in care — it is not necessary in every setting to document the details of traumatic incidents in depth

Trauma Exposures – A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.)

Trauma Reactions – The person's reaction to stressful situations (i.e., avoidance of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors

Trauma Screening- The 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

Systems Involvement – The person's experience with homelessness, juvenile justice involvement, or involvement in the child welfare system

DOMAIN 3

BEHAVIORAL HEALTH HISTORY

Focuses on history of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem

Mental Health History – Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included

Substance Use/Abuse – Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included

Previous Services – Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications, therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication for Addition Treatment [MAT]), length of treatment, and efficacy/response to interventions.

DOMAIN 4

MEDICAL HISTORY AND MEDICATIONS

Integrates medical and medication items into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides important context for understanding the needs of the people we serve

Physical Health Conditions – Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted

Medications – Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included

Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger)

CalMHSA

IMPORTANCE OF CURIOSITY WHEN ASSESSING

DOMAIN 5

PSYCHOSOCIAL FACTORS

Understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors)

Family - Family history, current family involvement, significant life events within family (e.g., loss, divorce, births)

Social and Life Circumstances – Current living situation, daily activities, social supports/networks, legal/justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community

Cultural Considerations – Cultural factors, linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other (LGBTQ+) and/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

Explores areas of risk for the individuals we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Clinicians should explore specific strengths and protective factors and understand how these strengths mitigate risks that the individual is experiencing

Strengths and Protective Factors – personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships

Risk Factors and Behaviors – behaviors that put the person in care at risk for danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/planning/intent, aggression, inability to care for self, recklessness, etc. Include triggers or situations that may result in risk behaviors. Include history of previous attempts, family history of or involvement in risks, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse), willingness to seek/obtain help. May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used

Safety Planning – specific safety plans to be used should risk behaviors arise, including actions to take and trusted individuals to call during crisis

DOMAIN 7

CLINICAL SUMMARY, TREATMENT RECOMMENDATIONS, LEVEL OF CARE DETERMINATION

Provides clinicians an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis

Clinical Impression – summary of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), 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 (to be explained further below)

Diagnostic Impression – clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified)

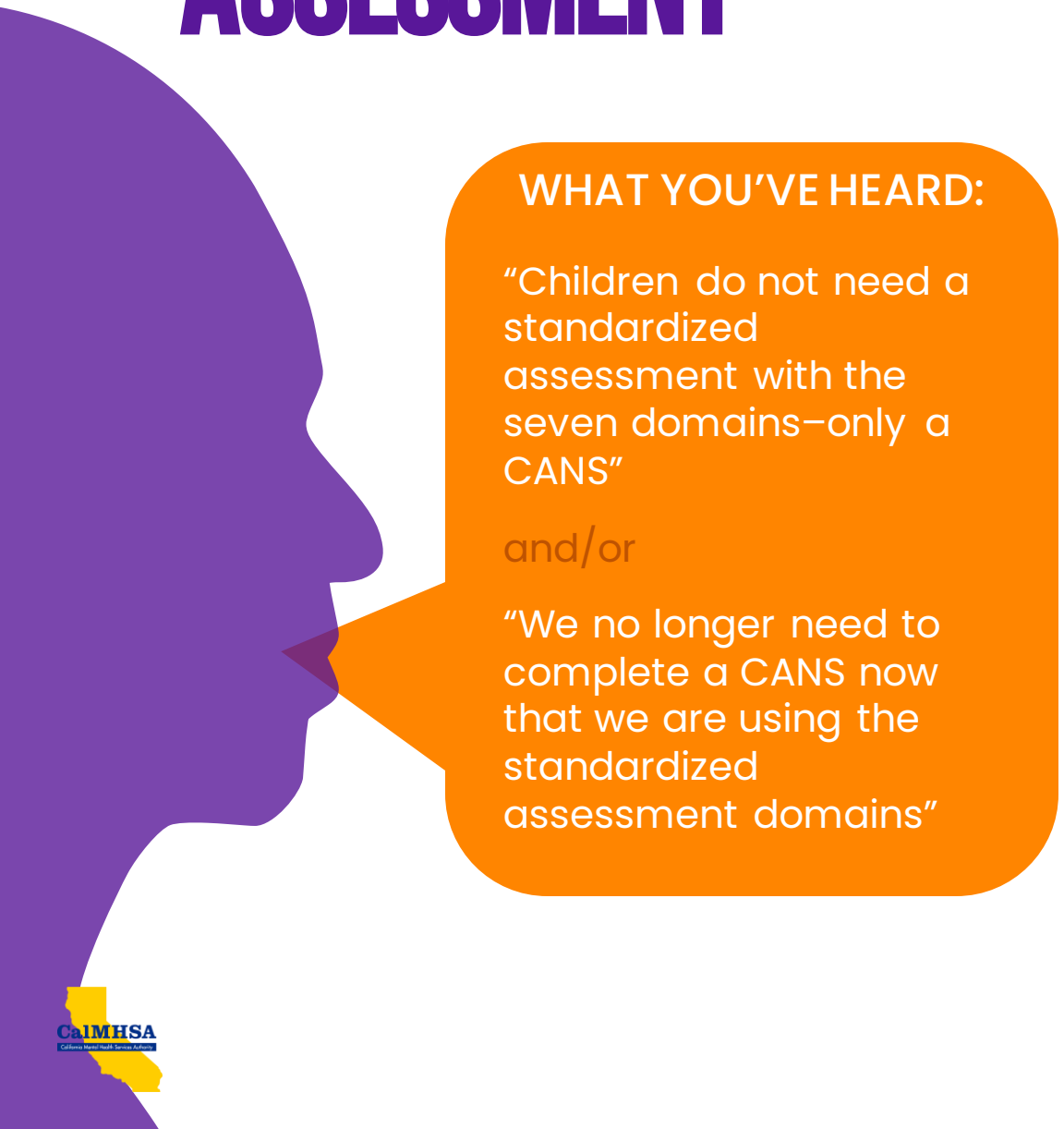
Treatment Recommendations – recommendations for detailed and specific interventions and service types based on clinical impression and, overall goals for care

ASSESSMENTS SUPPORT RELATIONSHIP BUILDING

EXPLORING STANDARDIZED ASSESSMENT MYTHS

DEEP DIVE

ASSESSMENT



WHAT YOU'VE HEARD:

"Children do not need a standardized assessment with the seven domains–only a CANS"

and/or

"We no longer need to complete a CANS now that we are using the standardized assessment domains"

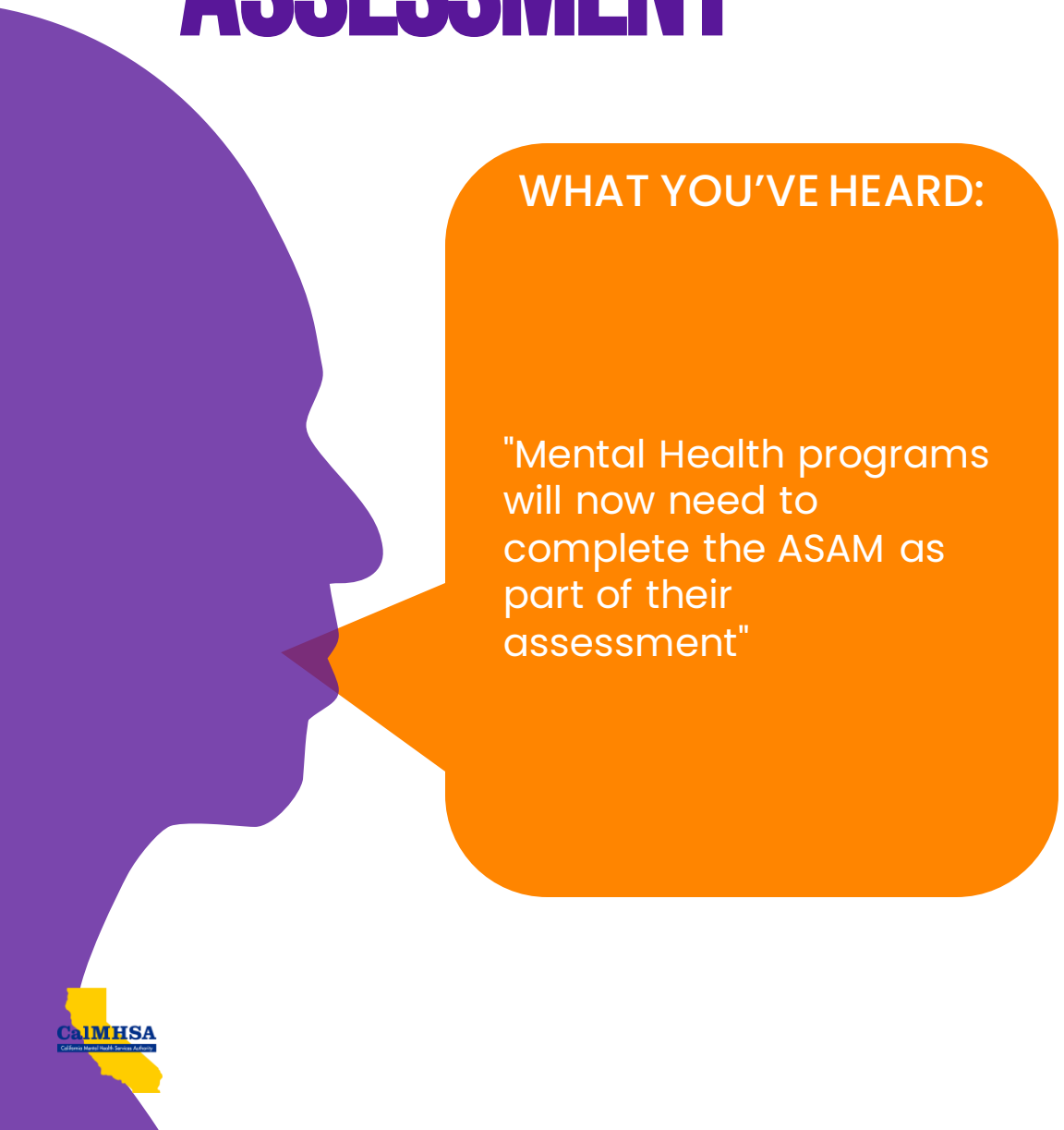
REAL DEAL

The seven standardized assessment domains are required for all individuals (child and adult)

The CANS (as well as the PSC 35) is still required in addition to the seven standardized assessment domains and can be utilized to inform the assessment

DEEP DIVE - CONTINUED

ASSESSMENT



WHAT YOU'VE HEARD:

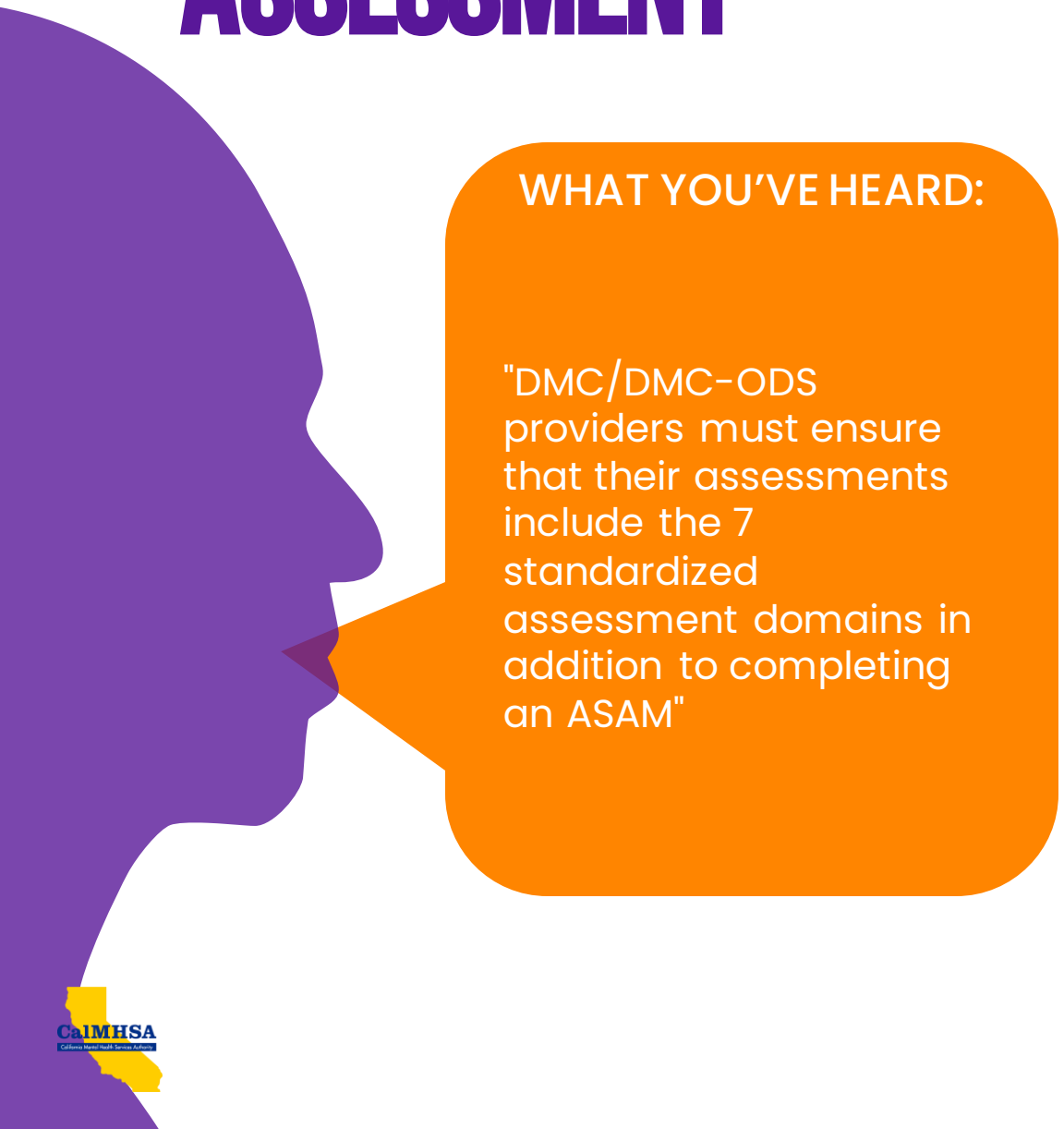
"Mental Health programs will now need to complete the ASAM as part of their assessment"

REAL DEAL

The ASAM is only required of DMC and DMC-ODS programs.

DEEP DIVE - CONTINUED

ASSESSMENT



WHAT YOU'VE HEARD:

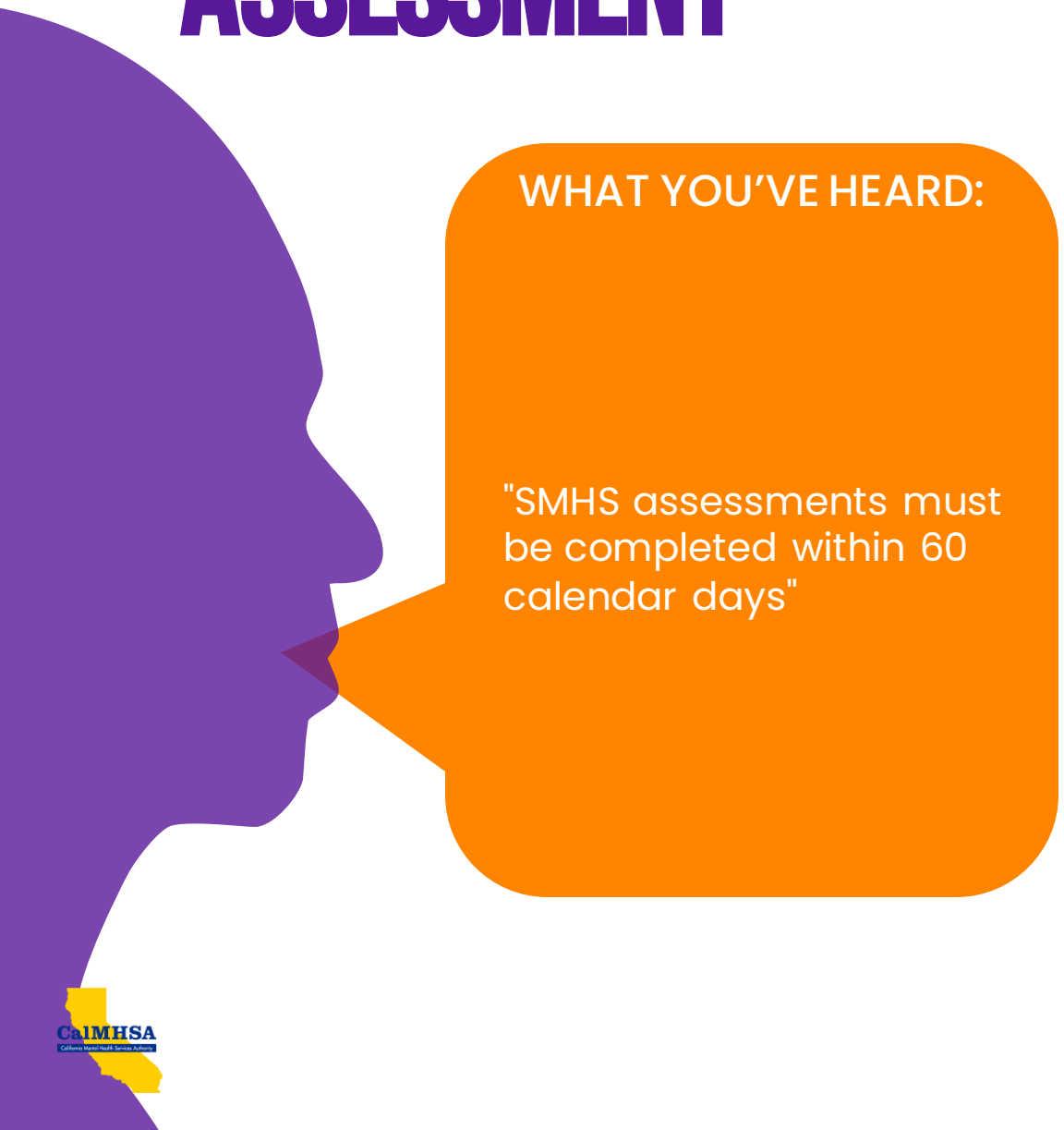
"DMC/DMC-ODS providers must ensure that their assessments include the 7 standardized assessment domains in addition to completing an ASAM"

REAL DEAL

DMC/DMC-ODS programs DO NOT need to utilize the 7 standardized assessment domains. DMC/DMC-ODS programs utilize the ASAM for their assessments.

DEEP DIVE - CONTINUED

ASSESSMENT



WHAT YOU'VE HEARD:

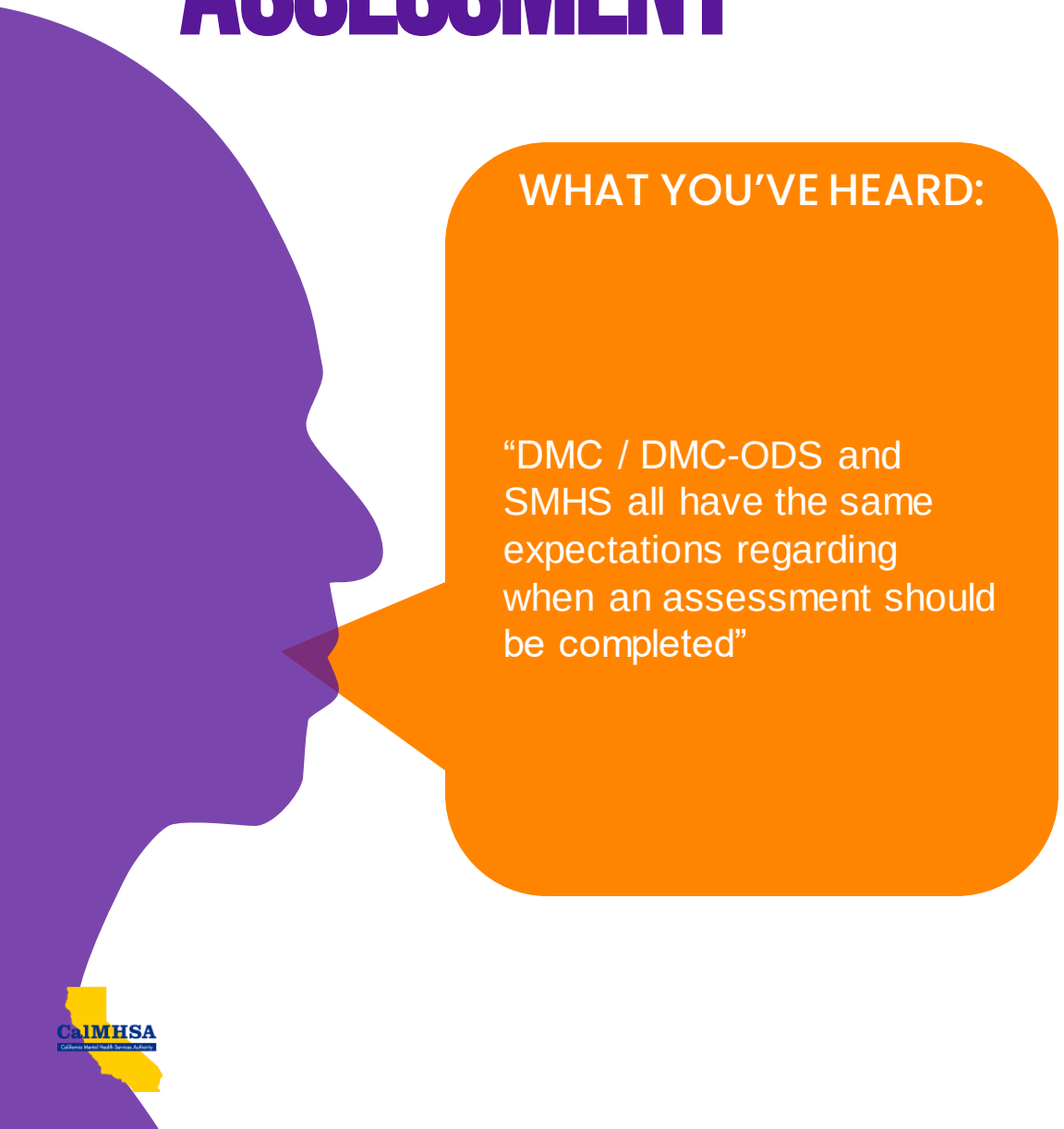
"SMHS assessments must be completed within 60 calendar days"

REAL DEAL

The time period for SMHS providers to complete an initial assessment is up to clinical discretion; however, providers must complete them within a reasonable time and in accordance with generally accepted standards of practice.

DEEP DIVE - CONTINUED

ASSESSMENT



WHAT YOU'VE HEARD:

"DMC / DMC-ODS and SMHS all have the same expectations regarding when an assessment should be completed"

REAL DEAL

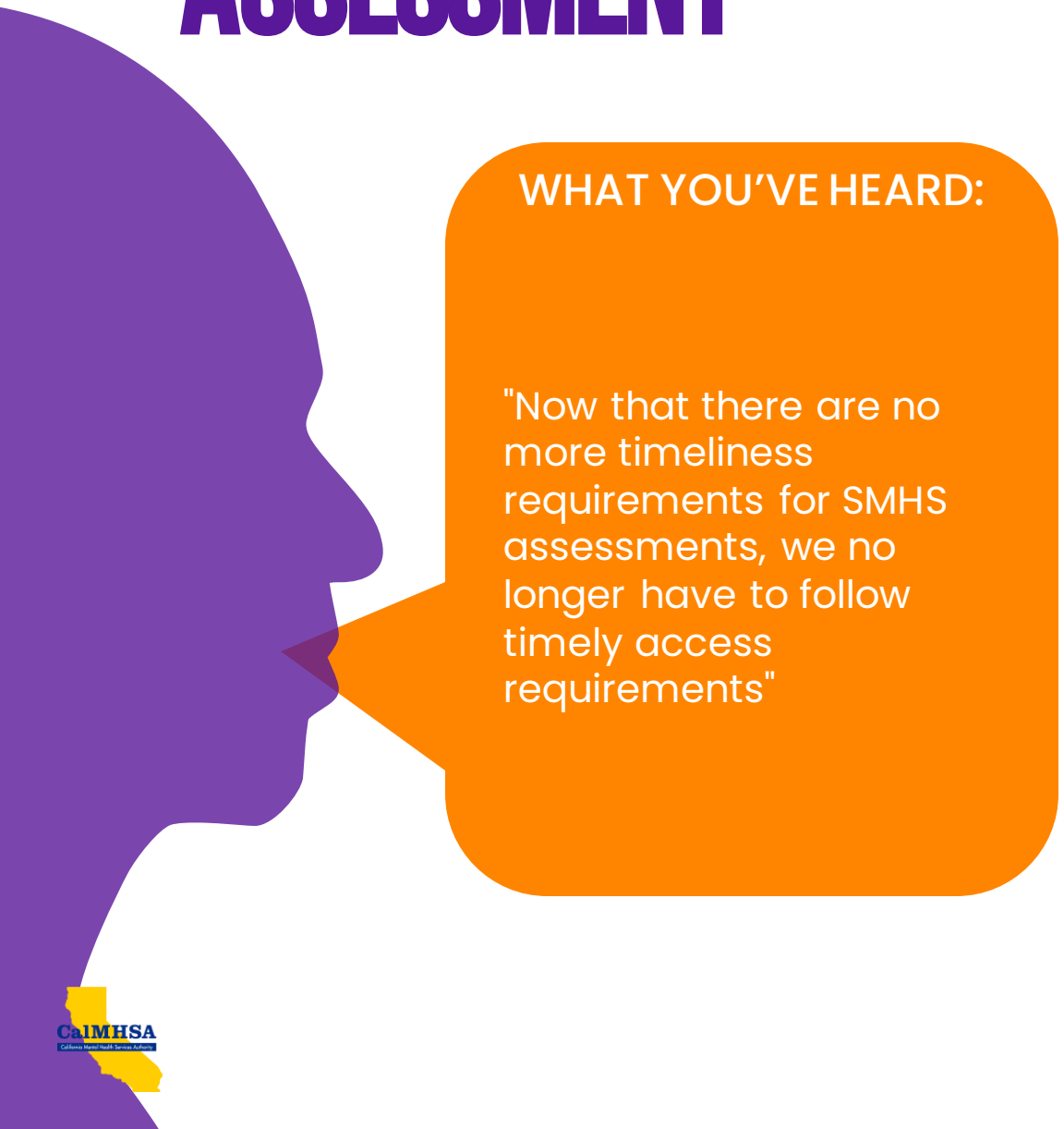
SMHS and DMC/DMC-ODS have slightly different rules:

For SMHS, it is up to clinical discretion; however, providers must complete them within a reasonable time and in accordance with generally accepted standards of practice

Covered and clinically appropriate DMC and DMC-ODS services (except residential) are Medi-Cal reimbursable for up to 30 days following the first visit with Licensed Practitioner of the Healing Arts (LPHA) or registered/certified counselor, whether or not a diagnosis is established, OR, up to 60 days if the beneficiary is under 21 or if the provider documents that the beneficiary is experiencing homelessness and more time is needed for an assessment.

DEEP DIVE - CONTINUED

ASSESSMENT



WHAT YOU'VE HEARD:

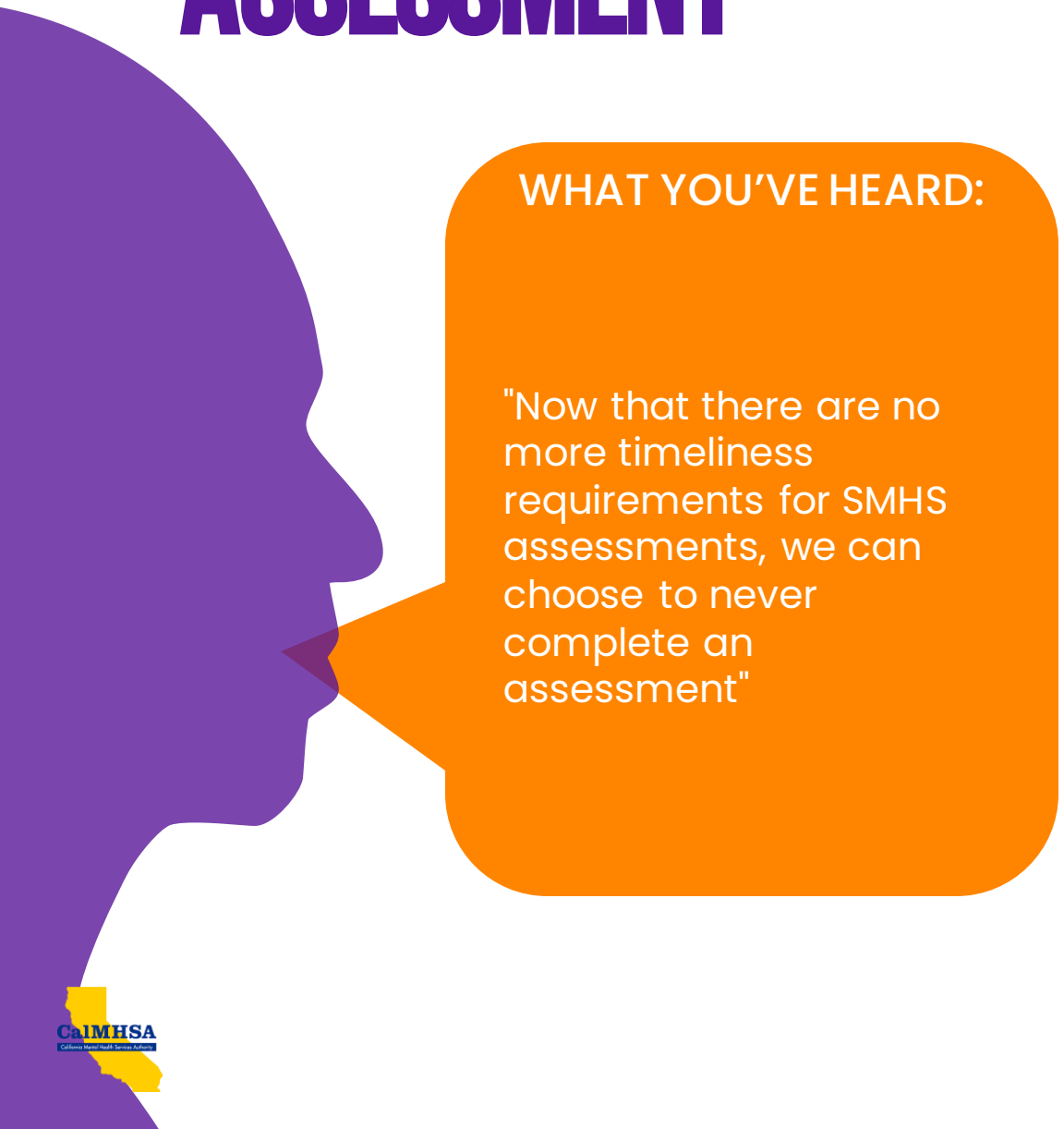
"Now that there are no more timeliness requirements for SMHS assessments, we no longer have to follow timely access requirements"

REAL DEAL

CalAIM assessment changes do not apply to the the pre-existing timely access requirements that all counties track and report.

DEEP DIVE - CONTINUED

ASSESSMENT



WHAT YOU'VE HEARD:

"Now that there are no more timeliness requirements for SMHS assessments, we can choose to never complete an assessment"

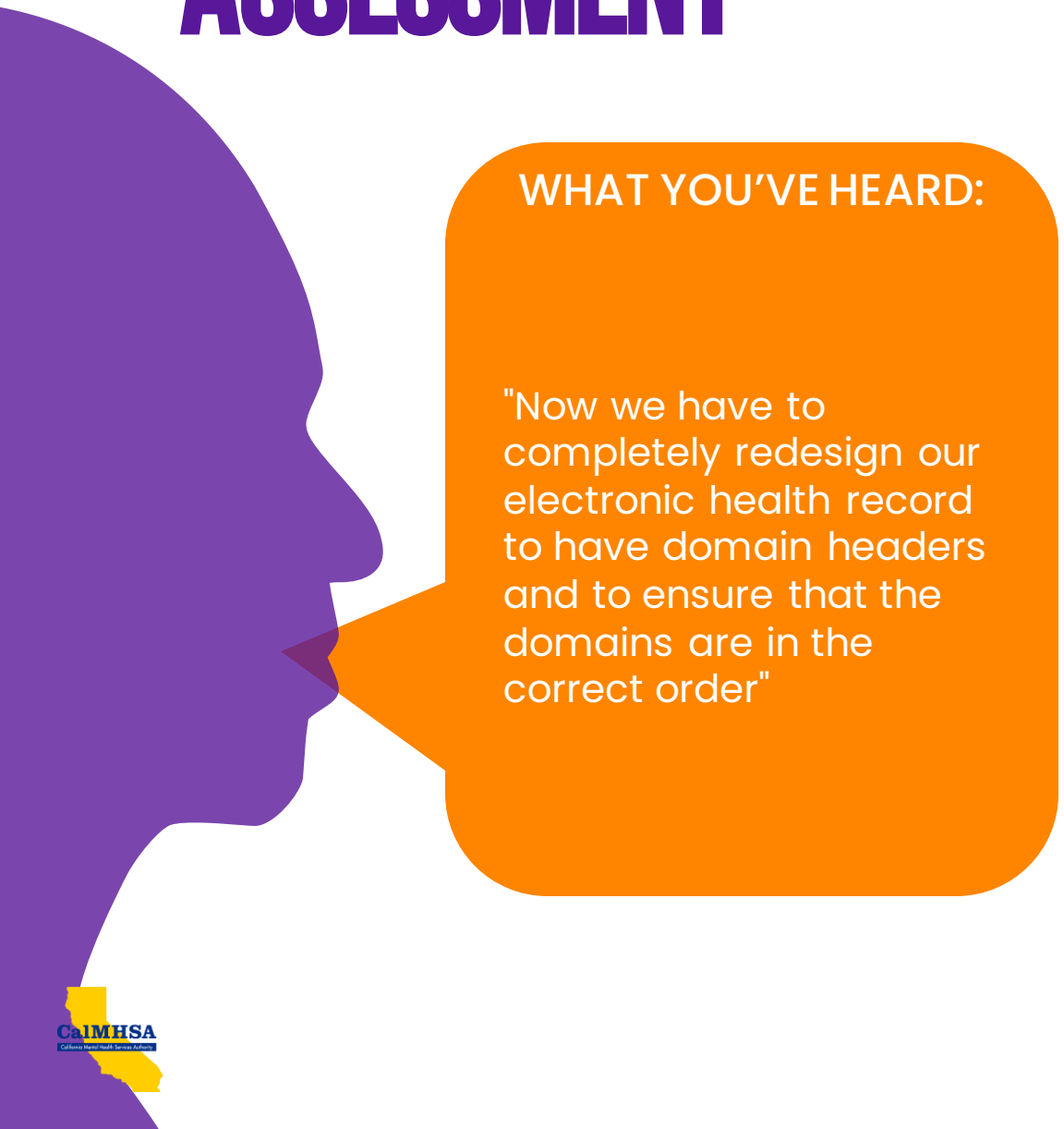
REAL DEAL

Providers must complete assessments within a reasonable time and in accordance with generally accepted standards of practice.

CalAIM providers more flexibility with regard to conducting and completing an assessment but that does not mean you never have to complete an assessment. That said, services provided in good faith during the assessment phase are reimbursable if the client withdraws from treatment prior to the completion of the assessment and determination of an official diagnosis.

DEEP DIVE - CONTINUED

ASSESSMENT



WHAT YOU'VE HEARD:

"Now we have to completely redesign our electronic health record to have domain headers and to ensure that the domains are in the correct order"

REAL DEAL

It would be ideal for the assessment domains to be organized within the electronic health record. However, it is not a requirement, as long as the existing assessment captures all the required elements (same for any providers who may be documenting on paper)

DEEP DIVE - CONTINUED

ASSESSMENT

WHAT YOU'VE HEARD:

"Now that there are no more timeliness requirements for SMHS assessments, the CANS and PSC-35 also have no timeliness guidelines.

REAL DEAL

NO CHANGES have been made to CANS and PSC-35 completion and reporting requirements.

Please note: That the DHCS does not require the ANSA and so there are not DHCS required guidelines for its completion.

DEEP DIVE - CONTINUED

ASSESSMENT

WHAT YOU'VE HEARD:

"Z codes cannot be used alone without a corresponding "real" diagnosis."

REAL DEAL

For some service types or settings, it may be challenging to justify ongoing medical necessity without a formal Mental, Behavioral and Neurodevelopment Disorders, "F-Code" diagnosis (e.g., Depressive Disorder or Schizophrenia).

However, in some settings or for some service types, particularly with children and youth, services can more easily be justified based only on Z codes.

ONLY Z CODE – CHILDREN

Child Welfare Outpatient Service

Youth was admitted for treatment based on history of trauma and involvement in the child welfare system; however, does not meet criteria for PTSD or another formal diagnosis. Needs help with family dynamics social challenges and emotionality. Has several Z codes, including:

- Encounter for Mental Health Services for Victim of Child Neglect by Parent (Z69.010)
- High Expressed Emotional Level within Family (Z63.8)
- Parent Child Relational Problem (Z62.820)
- Unspecified Problem Related to Social Environment (Z60.9)

Note: This would not necessarily be applicable to all children served but rather, is an example of a scenario where it might make sense for a Z code to be utilized indefinitely.

ONLY Z CODE – ADULTS

A Z code alone could be utilized while a clinician takes time to gather information about the individual's presenting needs and determine the most appropriate diagnosis and next steps. However, the Z code should not be utilized indefinitely (given the access to SMHS criteria for individuals 21 and up)

FEEDBACK? QUESTIONS?

Calaim@calmhsa.org

Thank You!

PLEASE CLICK THE NEW SURVEY MONKEY LINK IN THE CHAT TO COMPLETE OUR POST-TRAINING EVALUATION

THANK YOU!