



Instruction Guide for the Behavioral Health Clinical Chart Audit

Initial Release Date: April 19, 2023

Version 1.0

Re-release Corrected Version: April 26, 2023

Version 2.0

Re-release Corrected Version: May 31, 2023

Version 3.0

Re-release N/A Revisions: September 6, 2023

Version 4.0

<u>INTRODUCTION.....</u>	<u>4</u>
<u>AUDIT TOOL STRUCTURE AND PURPOSE</u>	<u>5</u>
<u>ASSESSMENT COMPONENTS REQUIRED ELEMENTS AND GUIDELINES</u>	<u>6</u>
• <u>A-1 Assessment Completion</u>	<u>7</u>
• <u>A-2 BHP Assessment Signature.....</u>	<u>7</u>
• <u>A-3 Presenting Concerns.....</u>	<u>8</u>
• <u>A-4 Physical and Behavioral Health Information.....</u>	<u>8</u>
• <u>A-5 Current/Past Medication.....</u>	<u>8</u>
• <u>A-6 Family History.....</u>	<u>9</u>
• <u>A-7 Developmental History.....</u>	<u>9</u>
• <u>A-8 Trauma History.....</u>	<u>10</u>
• <u>A-9 Risk of Exploitation.....</u>	<u>10</u>
• <u>A-10 Substance Use</u>	<u>11</u>
• <u>A-11 Living Environment</u>	<u>11</u>
• <u>A-12 Socialization</u>	<u>12</u>
• <u>A-13 Education and/or Vocational Training</u>	<u>12</u>
• <u>A-14 Employment</u>	<u>12</u>
• <u>A-15 Public and Private Resources</u>	<u>13</u>
• <u>A-16 Involvement of Health Care Decision Maker (HCDM)</u>	<u>13</u>
• <u>A-17 COE/COT Involvement</u>	<u>14</u>
• <u>A-18 Criminal Justice</u>	<u>14</u>
• <u>A-19 Communication Accommodations.....</u>	<u>15</u>
• <u>A-20 Risk Assessment.....</u>	<u>15</u>
• <u>A-21 Mental Status Exam</u>	<u>16</u>
• <u>A-22 Diagnostic Impression.....</u>	<u>16</u>
<u>SERVICE PLAN REQUIRED ELEMENTS AND GUIDELINES.....</u>	<u>16</u>
• <u>SP-1 Current Service Plan</u>	<u>17</u>
• <u>SP-2 Review of Service Plan.....</u>	<u>17</u>
• <u>SP-3 Signature of Service Plan.....</u>	<u>17</u>
• <u>SP-4 Living Environment.....</u>	<u>18</u>
• <u>SP-5 Socialization</u>	<u>18</u>
• <u>SP-6 Education and/or Vocational Training.....</u>	<u>19</u>
• <u>SP-7 Employment</u>	<u>19</u>
• <u>SP-8 Member/Family Vision</u>	<u>19</u>

- [SP-9 Member/Family Goals 20](#)

[GENERAL CLINICAL CHART REQUIRED ELEMENTS AND GUIDELINES 20](#)

- [GCC-1 Review of Service Options \(Voice and Choice\) 20](#)
- [GCC-2 Natural Supports..... 21](#)
- [GCC-3 Participation of Others 21](#)
- [GCC-4 Peer Support and Family Support 22](#)
- [GCC-5 Service Time Frames 22](#)
- [GCC-6 CALOCUS Assessment 23](#)
- [GCC-7 High Needs Case Manager 23](#)
- [GCC-8 Point of Contact for Member Coordination 23](#)
- [GCC-9 Collaboration 24](#)
- [GCC-10 Safety Planning 24](#)
- [GCC-11 Engagement/Re-engagement..... 25](#)
- [GCC-12 Transition Age Youth 26](#)
- [GCC-13 SMI Determination 26](#)
- [GCC-14 Special Assistance/SMI Designation 27](#)
- [GCC-15 Impact of Service Planning 27](#)

[CULTURAL COMPETENCY REQUIRED ELEMENTS AND GUIDELINES 28](#)

- [CC-1 Cultural Customs/Values/Beliefs/Structure 29](#)
- [CC-2 Preferred Language-Oral..... 29](#)
- [CC-3 Preferred Language-Written 29](#)

INTRODUCTION

The Behavioral Health Clinical Chart Audit tool has been developed by AHCCCS over time, through collaborative efforts with AHCCCS health plans, community stakeholders, and providers. The tool is updated regularly, based on changing requirements at the federal and state level, which in turn impact changes within AHCCCS policy and contract.

The AHCCCS policies utilized for purposes of tool element inclusion and audit instructions are as follows:

AHCCCS Medical Policy Manual (AMPM)			
AMPM 100	Manual Overview	AMPM 320-R	Special Assistance for Members with Serious Mental Illness
AMPM 220	Child and Family Team	AMPM 320-U	Pre-Petition Screening, Court Ordered Evaluation, and Court Ordered Treatment
AMPM 240	Family Involvement in the Children’s Behavioral Health System	AMPM 520	Member Transitions
AMPM 250	Youth Involvement in the Children’s Behavioral Health System	AMPM 541	Coordination of Care with Other Government Agencies
AMPM 280	Transition to Adulthood	AMPM 570	Provider Case Management
AMPM 310-B	Title XIX XX1 Behavioral Health Services Benefit	AMPM 590	Behavioral Health Crisis Services and Care Coordination
AMPM 320-O	Behavioral Health Assessments and Treatment Service Planning	AMPM 940	Medical Records and Communication of Clinical Information
AMPM 320-P	Serious Mental Illness Eligibility Determination	AMPM 1040	Outreach, Engagement and Re-Engagement for Behavioral Health
AMPM 320-Q	General and Informed Consent		

AHCCCS Contractor Operations Manual	
ACOM 405	Cultural Competency, Language Access Plan and Family-Member Centered Care
ACOM 417	Appointment Availability, Transportation Timeliness, Monitoring, and Reporting
ACOM 449	Behavioral Health Services for Children in Department of Child Safety (DCS) Custody and Adopted Children

Foster Care Litigation Revised Settlement Agreement
B.K. ex rel. Tinsley, et al. v. Faust, et al., CV-15-00185-PHX-ROS (August 14, 2020)

AUDIT TOOL STRUCTURE AND PURPOSE

General Information

The Arizona Health Care Cost Containment System (AHCCCS) supports a model for assessment, service planning and service delivery that is strength-based, tailored to the member and family, provided in the most appropriate setting, in a timely fashion and in accordance with best practices that are family friendly, culturally sensitive, clinically sound and supervised. The model is based on three equally important components:

1. Input from the member and family/significant others regarding their special needs, strengths, and preferences,
2. Input from other individuals who have integral relationships with the member, and
3. Clinical expertise.

The purpose of this instruction manual is to provide an in-depth understanding about how to effectively and efficiently review a clinical chart using the Behavioral Health Clinical Audit Tool, as developed by AHCCCS. **It is AHCCCS' expectation that the audit process satisfies ADHS requirements identified under A.A.C. R9-10-10 and A.A.C. R9-21-3, in addition to AHCCCS policy and contract and the standards identified within this instructional document. This document sets forth the standards that AHCCCS contracted health plans will use when they conduct behavioral health clinical chart audits.**

The information provided outlines the expectations of scoring for each section of the audit tool, so that auditors and providers can clearly understand what the expectations are for the assessment and service planning for AHCCCS members. **No other guidelines or instructions are to be utilized for the purpose of scoring audit items. A written request to AHCCCS for any recommendations for modifications to the instructions or methodology, as identified in Section F, Attachment F3 Contractor Chart of Deliverables for Behavioral Health Clinical Chart Audit Methodology. Any request for revisions will be internally reviewed by AHCCCS, and if approved, will be made by AHCCCS directly within the tool and/or instructions as applicable. Updated versions of the instructions, methodology, or tool will be distributed directly from AHCCCS.**

The Clinical Chart Behavioral Health Audit tool is made up of four sections:

Section I: The Assessment is defined in contract as “An analysis of a patient’s needs for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient.”

Section II: The Service Plan is defined in contract as “A complete written description of all covered health services and other informal supports, which includes individualized goals, peer and recovery support and family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.” The Clinical Chart Behavioral Health Audit tool is used to ensure that the Service Plan reflects needs identified within the assessment.

Section III: The General Clinical Chart section is designed to focus on evidence that demonstrates the member is achieving personal and recovery goals. This section is also meant to identify the effectiveness of behavioral health services surrounding needs that are identified within the assessment and related Service Plan updates. Items included within the general clinical chart may include but are not limited to (a) progress notes, Child/Family Team (CFT) or Adult Recovery Team (ART) documentation, (c) Transition Age Youth (TAY) activities, (d) CALOCUS or other assessment documents, (e) High Needs Case Manager involvement, (f) other screening tools utilized based on clinical need.

Section IV: The Cultural Competency section is designed to reflect the culture and identity of the member or child and family or HCDM, regarding race, and ethnic background, national origin, color, sex, sexual orientation, gender identification or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

The audit tool has been designed to apply to any population receiving behavioral health services. It allows for the use of “N/A” for audit elements that may not be applicable based upon contract type, age, or mental health category of the member. The questions were carefully crafted to allow for the auditor to verify that evidence exists for each required audit element. Responses will allow for scoring as follows: score “1” for yes and score “0” for no. When applicable, an N/A option is allowable. *All N/A options are scored as “0” or “null” and do not count for or against the total score. This is a change in logic from the original scoring guidelines as of the version dated September 6, 2023 (Version 4).*

Any item on its own shall **not** be used to validate payment or medical necessity for services rendered, even if scored as “No.”

A member may always decline to provide information for an audit element. This shall be documented in the clinical chart that the member declined to provide or does not have the information. When documentation exists regarding member declination to respond or decline the service or need, it shall be counted as a yes to satisfy scoring. If there is a lack of documentation to reflect member’s declination, the element shall be scored as no.

ASSESSMENT COMPONENTS REQUIRED ELEMENTS AND GUIDELINES

This section is designed to evaluate items within the most recent version of an assessment completed for a member. The Assessment is designed to address a member’s current needs, but also to allow for reassessments as needed (significant events or changing needs as identified by the member), and as based on required time frames. Reassessments allow for ongoing evaluation as it progresses to create a more comprehensive portrait of a member’s needs and strengths. Reassessments done for significant changes or annually as indicated in policy and contract should evaluate progress or lack thereof and adjust treatment accordingly. During reassessment an assessor shall determine and indicate if there have been any changes to the required elements since the last assessment and may indicate no change. There are no specific assessment forms required, as long as the assessment fulfills requirements identified within AHCCCS policy and contract. An assessment may also include other assessment tools, screenings, or evaluations, designed to identify, or justify medical necessity for member service delivery. This may include, but is not limited to psychiatric or psychological evaluations, standardized assessments

designed to address specific needs (e.g., depression, anxiety, need for health-related social needs (e.g., depression, anxiety) or assessments from other providers designed to meet the member's treatment needs. Additional assessments, screenings, or evaluations may be found in other sections of the clinical chart (e.g., General Clinical Chart).

Each element shall be audited relative to the requirements within that element. The criterion for each element is either met or not met according to the requirements, guidelines, and scoring criteria. Responses to indicate N/A will not be utilized as an indicator that the element cannot be scored when the assessment does not meet criteria, based on lack of timeliness or BHP signature requirements. There may also be evidence of assessment activity within other areas of clinical documentation that may satisfy individual assessment elements.

Assessment Requirements/Guidelines and Scoring:

Assessment (A-1): Assessment

Requirements/Guidelines: There is evidence that the member has had an assessment conducted within the last 12 months, that is included within the clinical chart.

This item is not specific to an initial, comprehensive, or reassessment. It is intended to validate the presence of an assessment having been completed with the member within the last 12 months. If there is not an assessment within the chart that is within the 12-month timeframe, it shall not render the entire assessment as invalid, but shall be scored as a no for this item.

If an assessment has been completed by another provider, or prior to behavioral health outpatient treatment, or if the outpatient behavioral health facility has a medical record for the patient that contains an assessment that was completed within 12 months before the date of the patient's current admission, the patient's information shall be reviewed and updated if additional information that affects the patient's assessment is identified. The review and updated information shall be documented in the member's record within 48 hours after the review is completed. This assessment can serve to meet the needs of service planning, CFT or ART activities until reassessments can be completed by the provider currently serving the member.

Scoring:

Yes: If there is evidence within the clinical chart that an assessment was (either initial or reassessment) conducted within the last 12 months.

No: If the clinical chart does not contain an assessment, or the assessment is more than 12 months old.

Assessment (A-2): Behavioral Health Professional (BHP) Signature

Requirements/Guidelines: There is evidence that the assessment was completed and signed by a BHP or completed by BHT/BHPP and cosigned by a BHP.

The intent of this audit item is to ensure that the assessment was either completed by a behavioral health professional or, if the assessment was conducted by a Behavioral Health Technician (BHT) or Behavioral Health Paraprofessional (BHPP), it has been reviewed and validated by a BHP. If the BHP

signature is not present, OR if it is present, but the review and signature was not completed within a 72-hour time frame as required by the Arizona Department of Health Services (ADHS), the auditor may document this to determine if a performance improvement plan, or referral to the ADHS is necessary.

Scoring:

Yes: The assessment was completed and signed by a BHP, or if completed by a BHT or BHPP, that it was reviewed and signed by a BHP.

No: The assessment was not signed by BHP.

Assessment (A-3): Presenting Concerns

Requirements/Guidelines: There is evidence within the assessment of the member's presenting concerns.

The intent of this item is to verify that the assessor has collected information regarding the immediate concerns of the member and/or their family and the reasons behavioral health services are being requested. The information obtained provides context to develop both service and discharge plans.

Scoring:

Yes: The assessment includes documented presenting concerns and reason or reasons the member is seeking services.

No: The assessment does not include documentation of presenting concerns and reason or reasons the member is seeking services.

Assessment (A-4): Physical and Behavioral Health Information

Requirements/Guidelines: There is evidence within the assessment to reflect physical and behavioral health conditions and diagnostic information.

The intent of this item is to verify that the assessor has collected information about a member's current and past health concerns and treatment to formulate a comprehensive understanding of the member's needs. This is important as health concerns may not only impact but may also mimic behavioral health disorders, and treatments offered may affect behavioral health treatment.

Scoring:

Yes: The assessment documents the current and past health conditions (physical and behavioral health) of the member. For annual assessments, the assessor may review previously provided information with the member, ask about any changes, or recent appointments and indicate no change if there have been no changes since the last assessment.

No: The assessment does not include information about the current and past health conditions of the member or no documented evidence to confirm that no changes have occurred.

Assessment (A-5): Current/Past Medication

Requirements/Guidelines: There is evidence within the assessment to reflect current/past medication information (physical and/or behavioral health).

Medication may include prescriptions, vitamins, and natural remedies. The auditor may look for information related to medication utilization that has been provided in previous assessments and indicate no changes if there have been no changes since the last assessment. The assessor's documented efforts to receive records will be given credit even if records have not yet been received. If an assessor indicates no current or past medications, this item is considered assessed and will be given credit.

Scoring:

Yes: There is evidence to reflect current/past medication information for physical and/or behavioral health needs or there is evidence that information has been requested from other providers but has not yet been received.

No: There is no evidence within the assessment that includes current/past medication information (physical and/or behavioral health) or documentation as to why there is no medication information included within the chart.

Assessment (A-6): Family History

Requirements/Guidelines: There is evidence within the assessment to identify family history regarding physical and/or behavioral health concerns.

By exploring family history, the assessor helps to identify the presence of familial, genetic, and environmental influences. Members may not know their family history and then documentation should be present to indicate members do not know their family history. The assessor may review previously collected family history. If there have been changes this information will be included, but if there have been no changes the assessor can indicate no change. Information may also be located within other areas of the clinical chart to identify that family history has been gathered previously.

Scoring:

Yes: The assessment documents identification of family history regarding physical and/or behavioral health needs, OR if family history has been gathered previously, there is documentation that there are no changes in family history.

No: The assessment does not include information of family history regarding physical and/or behavioral health needs and there is no indication that this information was previously gathered.

Assessment (A-7): Developmental History

Requirements/Guidelines: There is evidence that developmental history has been discussed with the member and/or guardian (birth and prenatal history if available).

The intent of this item is to verify the assessor documents key elements of the member's social, emotional, and physical skill development. Developmental history should be completed for all members participating in an assessment. Developmental history may also include birth and prenatal history, if available. Although developmental history is typically gathered during the initial meeting with the member and/or family, caregiver, etc., it is important to recognize that based on member need, development may need to be reexamined in subsequent assessments. If developmental history has

been gathered previously, documentation should be present to indicate that there are no changes. This information may be gathered from the member, family member/caregiver, DCS or DES/DDD staff, and/or DES/DDD group home, as applicable.

Scoring:

Yes: There is evidence that developmental history is included within the assessment, or documentation that the developmental history is unavailable. If developmental history has been gathered previously, there is documentation that there are no changes in developmental history.

No: There is no evidence that developmental history is included within the assessment.

Assessment (A-8): Trauma History

Requirements/Guidelines: There is evidence that trauma history has been addressed (e.g., sexual abuse, domestic or community violence, neglect, natural disasters, victim, of criminal behavior, etc.).

The intent of this item is to verify that a member's history of trauma (e.g., sexual abuse, domestic or community violence, neglect, natural disasters, victim of criminal behavior, etc.) is assessed when clinically appropriate. A member's trauma history is taken into consideration to develop a more accurate understanding of their needs, to address presenting concerns, and to reduce re-exposure to traumatizing events when not clinically appropriate. The assessor may use a trauma screening tool (e.g., ACES, PEARLS, other evidence-based trauma screening tool), or include trauma history within the assessment. The assessor may also have documented that exploration of trauma history is not clinically appropriate at time of assessment.

Scoring:

Yes: There is evidence that trauma history is addressed, as outlined above within the assessment. Documentation exists to indicate that trauma history was obtained and evaluated previously, and clinical rationale identifies that trauma history does not need to be reexamined.

No: There is no evidence that trauma history was assessed or determined not appropriate with supporting clinical rationale as part of the assessment process.

Assessment (A-9): Risk of Exploitation

Requirements/Guidelines: There is evidence in the assessment to address potential risk for subjection to exploitation.

The intent of this item section is to determine the safety of the environment and risk of physical, sexual, and/or emotional exploitation. The assessment addresses the presence of concerns surrounding actions, inactions, or situations that may put the member or individuals in contact with the member at risk for sexual, emotional, physical, or financial exploitation.

Scoring:

Yes: There is evidence within the assessment that risk of exploitation was addressed, OR Documentation exists to indicate risk of exploitation was obtained and evaluated previously, and clinical rationale identifies the exploitation does not need to be reexamined.

No: There is no evidence within the assessment that the provider assessed for risk of exploitation. There is no evidence within the assessment to indicate the provider explored concerns surrounding exploitation or documented clinical rationale identifying that reexamination was not warranted.

Assessment (A-10): Substance Use

Requirements/Guidelines: There is evidence in the assessment to demonstrate that the member has been screened for substance use, and/or substance exposure.

The intent of this item is to ensure potential substance use or exposure is identified. This may include the use of a standardized screening or assessment, which may include but are not limited to American Society of Addiction Medicine (ASAM) criteria or ASAM Continuum, or CRAFFT. If a standardized screening tool is not utilized, there is evidence that the assessment includes questions that screen for substance use and/or substance exposure. If substance use or exposure is indicated, information gathered during this portion of the assessment will enable a plan to refer/seek services that will support harm reduction, recovery, and long-term sobriety. For children, the assessor will screen for substance exposure. Examples may include but are not limited to questions related to prenatal care or use the Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) screening tool. If the record does not include a standardized screening tool for substance abuse or questions that screen for substance use and/or substance exposure, the item shall be scored as “no”.

Scoring:

Yes: There is evidence that the member has been screened for substance use and/or substance exposure.

No: There is no evidence in the assessment to demonstrate that the member has been screened for substance use and/or substance exposure.

Assessment (A-11): Living Environment

Requirements/Guidelines: There is evidence that the member is assessed for needs related to living environment/situation (e.g., safety/security, housing, neighborhood, food, transportation, safety/access to weapons or firearms, etc.).

The intent of this item is to ensure the assessor has identified the potential impact of the member’s environment or living situation with regard to safety, access to food, transportation, etc. This may include the use of a standardized assessment or screening tool, including but not limited to the [Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences tool](#) (PRAPARE) or Accountable Health Communities’ 10-question [Health-Related Social Needs Screening Tool](#) (AHC-HRSN).

Scoring:

Yes: There is evidence within the clinical chart that the member was assessed for needs related to living environment.

No: There is no evidence that the member was assessed for needs related to living environment.

Assessment (A-12): Socialization

Requirements/Guidelines: There is evidence that the member is assessed for needs related to socialization (e.g., social supports, isolation, loneliness, recreational, and/or familial activities).

The intent of this item is to determine whether the member has access to social supports through interpersonal relationships or social activities that may facilitate a member's ability to achieve goals. Conversely, factors such as isolation and loneliness may negatively impact a member's ability to achieve desired goals. Evidence may include but is not limited to documentation reflecting who a member may use at times when support is needed (e.g., friend, family, clergy, community group). There may be documentation to indicate that the member does not utilize any social supports. This may include the use of a standardized assessment or screening tool, including but not limited to the [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool](#) (PRAPARE) or Accountable Health Communities' 10-question [Health-Related Social Needs Screening Tool](#) (AHC-HRSN).

Scoring:

Yes: There is evidence the member was assessed for needs related to availability of social support, level of isolation or loneliness, etc., regardless of whether the member is a child or an adult.

No: There is no evidence the member was assessed for needs related to availability of social support, isolation, loneliness, etc.

Assessment (A-13): Education and/or Vocational Training

Requirements/Guidelines: There is evidence that the member is assessed for needs related to education and/or vocational training.

The intent of this item is to ensure the assessor evaluates whether the member has current needs and goals related to education and vocational training. This may include education from preschool to college; scholarships, post-retirement, transition between schools or school-to-work, paid/nonpaid settings, volunteer activities, or internship opportunities. Depending on identified needs and goals of the member, the assessor may collect additional information related to strengths and barriers associated with engaging in education and vocational training.

Scoring:

Yes: There is evidence that the member is assessed for needs related to education and/or vocational training OR there is documentation to reflect that the member did not have any educational or vocational needs, or that it was deemed not appropriate at time of assessment for review based on clinical judgement.

No: There is no evidence that the member is assessed for needs related to education and/or vocational training.

Assessment (A-14): Employment

Requirements/Guidelines: There is evidence that the member is assessed for needs related to employment (e.g., work preference, need for employment supports, etc.).

The intent of this item is to ensure the assessor collected enough information to gain an understanding of the member's ability to obtain and maintain employment and the overall impact that employment has on the member's life. This may include but is not limited to employment status, work preference, desire for volunteer, or paid employment, need for employment supports, etc.). The assessor may also have identified strengths and potential barriers in getting, keeping, or maintaining employment or the ability to function in some settings and not others.

Scoring:

Yes: There is evidence that the member is assessed for needs related to employment.

No: There is no evidence that the member is assessed for needs related to employment.

N/A: Acceptable if the member is under the age of 16.

Assessment (A-15): Public and Private Resources

Requirements/Guidelines: There is evidence that member's needs are addressed related to public and private resources (e.g., transportation through the health plan, by a neighbor, family member, friend, etc.).

The intent of this item is to ensure the assessor has evaluated the member's awareness, access to, and utilization of public and private resources that may be available within their community to ensure unmet needs are addressed. This may include identification of and referral to resources to support the member in addressing unmet needs. This may involve referrals for food stamps, food banks, community support groups or systems, faith-based resources, etc., Health Risk Assessment (HRA) tools, such as but not limited to the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE). The PRAPARE tool can be used to assess a member's public and private resources.

Scoring:

Yes: There is evidence that member is assessed for awareness and utilization of public or private resources (e.g., cash assistance, food stamps, childcare, etc.) available to support member needs.

No: There is no evidence that member receives information on public or private resources available to support member needs.

Assessment (A-16): Involvement of Health Care Decision Maker (HCDM)

Requirements/Guidelines: There is evidence that the assessor determined the presence or absence of an HCDM, guardian, or conservator.

The intent of HCDM section is to ensure the assessor has identified the presence of an HCDM to include their involvement in behavioral health services. For adults, this may be an indicator to reflect the necessity of an HCDM due to the limited capacity of the adult. For children, this may be an indicator that the Arizona Department of Child Safety (DCS) is the legal entity. Legal documentation should be included within the medical record if indicated that such HCDM involvement is in place.

Scoring:

Yes: There is evidence that the assessor determined the presence or absence of an HCDM, guardian, or conservator.

No: There is no evidence that the assessor determined the presence or absence of an HCDM, guardian, or conservator.

Assessment (A-17): COE/COT

Requirements/Guidelines: There is evidence that the assessor determined the presence of a court order, or the need for a court ordered evaluation has been identified and screening agency has been notified.

The intent of this element is to ensure that members who may meet criteria for a court ordered evaluation (e.g., evidence that member may meet emergent or nonemergent criteria such as DTS/DTO or PAD/GAD), or are currently under a court order, are identified. For individuals who meet the criteria for a court ordered evaluation, they must also show documentation that they have been referred to an appropriate screening agency.

Scoring:

Yes: There is evidence that the assessor determined the presence of a court order or that a need has been identified for a court ordered evaluation and screening agency have been notified.

No: There is no evidence that the assessor determined the presence of a court order or the need for a court ordered evaluation.

N/A: N/A is acceptable for children less than 17 years and 6 months old or if the member is not court ordered to treatment or does not need a referral for a screening for a court ordered evaluation.

Assessment (A-18): Criminal Justice

Requirements/Guidelines: There is evidence that the member's current and past criminal justice involvement has been addressed through the assessment process.

The intent of this item is to ensure the assessor identified whether a member currently has been or previously was involved with the legal system in any capacity (e.g., legal issues, as a defendant/respondent (probation, arrests, parole, court-ordered treatment) or as a victim/plaintiff (victim, guardian of victim, etc.). Identification of criminal justice involvement is important when assessing risk and identifying service needs. This may include coordination with other involved agencies (Arizona Department of Corrections, Rehabilitation, and Reentry, Arizona Department of Juvenile Corrections, Probation Officer, etc.). Information from the criminal justice system, probation, parole, or other diversion services may provide important external supports that may be used in the initial service planning process.

Scoring:

Yes: There is evidence that the member's current and past criminal justice involvement (e.g., either as a defendant/respondent or victim/plaintiff) has been addressed through the assessment process.

No: There is no evidence that the member's current and past criminal justice involvement has been addressed through the assessment process.

Assessment (A-19): Communication Accommodations

Requirements/Guidelines: There is evidence that the member's needs have been assessed for assistance with communication capabilities (special accommodations for hearing, vision, cognitive, language interpretation, etc.)

The intent for this section is to ensure that members needing communication accommodations are identified as such. Criteria involve the inability to communicate preferences, or inability to participate effectively in service or discharge planning, and/or grievance and/or appeal process. An inability to communicate may be due to one of the following conditions (a) cognitive/intellectual capacity, (b) language barrier that cannot be addressed by translator/interpreter, (c) medical condition (including psychiatric symptoms), (d) Arizona Court has determined full and permanent legal guardianship for member.

If any of these elements are identified within the clinical chart, then that may be an indication that the member has been assessed for the need to receive communication accommodations.

Scoring:

Yes: There is evidence that the member's needs have been assessed for necessary communication accommodations.

No: There is no evidence that the member's needs have been assessed for assistance with communication capabilities (special accommodations for hearing, vision, cognitive, language interpretation, etc.).

Assessment (A-20): Risk Assessment

Requirements/Guidelines: There is evidence that a Risk Assessment was completed to assess the member's perception and/or level of safety in their current living environment.

The Risk Assessment section determines the member's overall ability to be safe in the community and assesses the need for immediate intervention (voluntary or involuntary). Factors may include plan, risk/intent to harm self or others, previous suicide attempts and self-harming behavior, impulsivity, access to weapons or other means of harm, the existence of a safe and supportive environment, level of cognitive functioning, level of impairment from physical factors, presence of substance use, presence, or lack of available supports. Reassessment may evaluate whether there have been any changes since the previous assessment. The assessor may have used a separate risk screening tool, such as (but not limited to) the Columbia-Suicide Severity Rating Scale (C-SSRS), or the assessment itself may include questions assessing a member's overall ability to be safe in the community and any need for immediate intervention. The assessor may determine that not all risk factors above need to be addressed and documented as such within the clinical record.

Scoring:

Yes: There is evidence of a risk assessment within the clinical chart.

No: There is no evidence of a risk assessment in the clinical chart.

Assessment (A-21): Mental Status Exam

Requirements/Guidelines: There is evidence of a mental status exam.

The intent of the Mental Status Exam (MSE) is to ensure the assessor summarized observations and impressions of the member's functioning at the time of the assessment. An MSE describes the member's speech, appearance, activities, thoughts, and attitudes during the interview process. There is no required template for MSE, it includes information gathered throughout the interview and varies based on the member's age. An MSE is commonly found within the Clinical Formulation in which the assessor provides a descriptive picture of the person through summarization of pertinent data for member's medical/ behavioral health history and mental status findings. Other areas of the clinical chart besides the assessment section, may contain evidence of an MSE.

Scoring:

Yes: There is evidence of a Mental Status Exam, included within the clinical chart.

No: There is no evidence of a Mental Status Exam, included within the clinical chart.

Assessment (A-22): Diagnostic Impression

Requirements/Guidelines: There is evidence of diagnostic impressions and a summary to support those diagnoses.

The intent of the Diagnostic Impression element is to synthesize information gathered during the assessment to evaluate for the appropriate Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses, or as applicable, provisional diagnoses. The diagnostic impression should also include supporting evidence of member's presentation and how this supports the diagnosis assigned, along with other diagnostic factors such as the medical condition of the person.

Scoring:

Yes: There is evidence of a diagnostic impression and an assigned diagnosis within the assessment.

No: There is no evidence of a diagnostic impression and assigned diagnosis present within the assessment.

SERVICE PLAN REQUIRED ELEMENTS AND GUIDELINES

This section is designed to evaluate the extent to which the service plan meets the needs of the member, family, or health care decision maker in determining the types and mix of services provided, based on vision, voice, and choice and within the least restrictive setting possible. Developing a successful service plan relies on an understanding from the outset of what the member, their family, and/or HCDM would like to achieve. The service plan should follow a strength-based approach and encourage the development of the needs identified and agreed upon within the assessment. The member will determine how they would measure success and what changes are personally most important and relevant. Attention should be paid to how the member/family interprets their own

culture, religion, family practices and/or adherence to specific beliefs and/or traditions. Service Plan development shall occur based on the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems and the 12 Guiding Principles for Children.

In collaboration with the member, the service plan should establish the member's desired outcomes. During subsequent reviews, the service plan should be updated to reflect progress toward achieving the member's desired outcomes.

Service Plan Requirements/Guidelines Scoring:

Service Plan (SP-1): Current Service Plan

Requirements/Guidelines: There is evidence that the service plan has been updated in conjunction with the most recent assessment completed.

The service plan should be updated in conjunction with the most recent assessment. The service plan shall be updated in conjunction with the assessment if completed in the same encounter with the member, and if the assessment indicated a change from what was originally identified as a need to be addressed in the service plan.

Scoring:

Yes: There is evidence within the clinical chart that a service plan was completed within the last year and that it was updated in conjunction with the most recent assessment.

No: There is evidence that the service plan in the clinical chart is **more than 1** year old, or that the service plan was not updated in conjunction with the most recent assessment.

Service Plan (SP-2): Review of Service Plan

Requirements/Guidelines: There is evidence that the service plan has been reviewed with the member and/or HCDM and that the provider obtained either verbal or written consent indicating agreement with the goals and services outlined in the service plan.

Scoring:

Yes: There is evidence in the clinical chart that verbal or written consent was obtained from the member or the HCDM that indicates agreement with the goals and services outlined in the service plan.

No: There is no evidence that verbal or written consent was obtained from the member or HCDM that indicates agreement with the Service Plan.

Service Plan (SP-3): Service Plan Signature

Requirements/Guidelines: There is evidence that the service plan has been completed and dated/signed by a BHP or BHT/BHPP and dated/cosigned by a BHP.

The intent of this element is to ensure that the service plan has been completed and that the appropriate oversight is being provided.

Scoring:

Yes: There is evidence that the Service Plan was completed and signed by a BHP or was completed by a BHT/BHPP, reviewed, and signed by a BHP.

No: There is no evidence of BHP signature and review, but the Service Plan was completed by a BHT/BHPP.

Service Plan (SP-4): Living Environment

Requirements/Guidelines: There is evidence that the Service Plan addresses needs identified and agreed upon within the assessment related to living environment/situation (e.g., safety/security, housing, neighborhood, food availability, transportation, access to weapons or firearms, etc.).

The intent of this element is to ensure the member's environment is assessed for safety and habitability (e.g., where and with whom one lives, neighborhood safety). Living environment influences the member's quality of life and ability to achieve their desired outcome may influence their ability to implement their service plan and who might be available for member support. During the service planning process, the member may decline to include a goal in the service plan regarding living environment. Efforts should be documented related to the assessor's attempts to engage the member in addressing the living environment. If securing a safe and appropriate living environment was identified as a need, the assessor should include this as a priority for service planning discussion.

Scoring:

Yes: There is evidence that living environment/situation is addressed on the service plan, OR if living environment was not identified as a need OR, there is documentation that a member declined to include a goal for living environment, even if it was assessed as a need.

No: There is evidence that living situation was identified as a need but is not addressed on the service plan.

Service Plan (SP-5): Socialization

Requirements/Guidelines: There is evidence that the service plan addresses the needs identified within the assessment related to socialization (e.g., social supports, isolation, loneliness, recreational, and/or familial activities).

Scoring:

Yes: There is evidence that the needs identified within the assessment related to socialization are addressed on the service plan, OR socialization was not identified as a need OR, there is documentation that a member declined to include a goal for socialization, even if it was assessed as a need.

No: There is evidence that socialization was assessed as a need but is not addressed on the service plan.

Service Plan (SP-6): Education and/or Vocational Training

Requirements/Guidelines: There is evidence that the service plan addresses the needs identified within the assessment, related to education/vocation (e.g., education, vocational or other similar needs as identified by the member).

The intent of the Educational/Vocational Training element is to ensure that identified and agreed upon needs from the assessment are addressed in the service plan.

Scoring:

Yes: There is evidence that Education and/or Vocational Training was identified and agreed upon as a need and is addressed on the service plan OR, if Education and/or Vocational Training was not identified as a need OR, there is documentation that a member declined to include a goal for Education and/or Vocational Training, even if it was assessed as a need.

No: There is evidence that Education and/or Vocational Training was assessed as a need but is not addressed on the service plan.

Service Plan (SP-7): Employment

Requirements/Guidelines: There is evidence that the service plan addresses the needs identified within the assessment related to employment (e.g., work preference, need for employment supports, volunteer activities, etc.).

The intent of the Employment element is to ensure that the identified and agreed upon needs from the assessment are addressed in the service plan.

Scoring:

Yes: There is evidence that Employment was identified and agreed upon as a need and is addressed on the service plan OR, employment was not identified as a need OR, there is documentation that a member declined to include a goal for Employment, even if it was assessed as a need.

No: There is evidence that Employment was assessed as a need but is not addressed on the service plan.

N/A: An N/A is acceptable if the member is under the age of 16.

Service Plan (SP-8): Member/Family Vision

Requirements/Guidelines: There is evidence that the member/family vision is documented and that the Service Plan has goals that are based on the member/family vision.

This section should describe a sense of where the person wants to be and how they will know when services are no longer needed. The vision should provide a description of how the member would like their life, family, and environment to be once services are no longer needed.

Scoring:

Yes: There is evidence of a member/family vision, and the service plan goals are based on the member/family vision.

No: There is no evidence of a member/family vision, or the service plan goals are not based on the member/family vision.

Service Plan (SP-9): Member/Family Goals

Requirements/Guidelines: There is evidence that the Service Plan has goals that utilize the strengths identified in the assessment and service planning process.

The intent of the member/family goals element is to ensure that service plan goals utilize the member and/or family's strengths were identified through the assessment process. Strengths may include internal strengths of the member or family, application of their strengths and/or support available to the member.

Scoring:

Yes: There is evidence that the goals on the Service Plan utilize the member and/or family strengths identified in the assessment and service planning process.

No: There is evidence that the goals on the Service Plan do not utilize the strengths identified in the assessment and service planning process.

GENERAL CLINICAL CHART REQUIRED ELEMENTS AND GUIDELINES

The General Clinical Chart Section is designed to focus on requirements that may be included in various areas of the clinical chart, such as the Assessment, Service Plan, progress notes, or CFT/ART notes. The general clinical chart may also contain evidence of referrals to or from other providers, behavioral health and/or medical documentation from other providers, and any other information related to member needs, delivery, and coordination of services.

General Clinical Chart Requirements/Guidelines and Scoring

General Clinical Chart (GCC-1): Review of Services Options (Voice and Choice)

Requirements/Guidelines: There is evidence within the clinical chart that the member was made aware of providers and the option to choose from an array of providers for services included on the Service Plan (voice and choice).

The intent of this element is to ensure that when services are included on the service plan, the member is made aware and given the option to choose from an array of service providers (e.g., through health home, outpatient behavioral health clinic, Community Service Organizations [CSA]s, **and** peer and family run organizations). The provider may document that the member was provided the health plan website information and/or that the provider assisted the member in performing provider search functions within the health plan website. Documentation within progress notes should indicate discussion of member voice and choice of service providers.

Scoring:

Yes: There is evidence that the member was made aware of provider options and given the opportunity to accept or decline specific providers.

No: There is no evidence to demonstrate that the member was given provider options or given the opportunity to accept or decline specific providers.

General Clinical Chart (GCC-2): Natural Supports

Requirements/Guidelines: There is evidence within the clinical chart that the provider discussed and assisted the member/family in identifying informal or natural supports.

The intent of this element is to explore the identification of natural supports within a member's life. Natural supports may include family members, friends, faith-based community supports or other informal services that the member may choose to utilize to achieve desires and goals as identified within the service plan or CFT/ART process.

Scoring:

Yes: There is evidence in the members clinical chart that the provider discussed and assisted the member/family in identifying informal or natural supports.

No: No evidence in the clinical chart to show that informal or natural sources of support were identified.

General Clinical Chart (GCC-3): Participation of Others

Requirements/Guidelines: There is evidence in the clinical chart that the member/family was given the opportunity to include other individuals (e.g., family members, friends, clergy, teachers, other agency staff) in the service planning or CFT/ART activities.

The intent of this element is to ensure that the member was notified of the opportunity to invite others (e.g., stakeholders, advocates, clergy, teachers, other agency staff) to participate in the Service Planning and Service Delivery. This may include others that have been or may need to be involved in the member's care such as family, friends, clergy, individuals from other systems (e.g., DES/DDD, probation, education). It is the member's choice to include meaningful persons, but it is not a requirement. Designated representatives, agency representatives, and other involved parties, as applicable, may be invited to participate in the development of the service plan as seen in documentation within the clinical chart.

Scoring:

Yes: There is evidence in the clinical chart that the member/family was given the opportunity to include other individuals in the service planning. Designated representatives, agency representatives, and other involved parties, as applicable, may be invited to participate in the development of the service plan as seen in documentation within the clinical chart.

No: There is no evidence in the clinical chart to show that the member/family was given the opportunity to include other individuals in service planning.

General Clinical Chart (GCC-4): Peer Support; Family Support

Requirements/Guidelines: There is evidence in the clinical chart that the member/family has been informed of and offered peer support or family support services, as appropriate based on age of member.

The intent of this element is to identify that the member/family received information on the availability of peer/family support services and were offered a referral, as applicable. If the member declined to receive peer/family support services, there is no need to verify that a referral was completed. If the member requested to receive peer/family support services, there shall be documentation of a referral, either internal or external, for those services to be initiated. In order to score this item as yes, the auditor must confirm that the provider's offering of peer/family support, is accompanied by documentation that the member/family was offered the choice of providers for this service (e.g., through health home, outpatient behavioral health clinic, Community Service Organizations (CSA)s, and peer and family run organizations).

Scoring:

Yes: There is evidence in the clinical chart that the member/family has been informed of and offered peer support or family support services.

No: No evidence in the clinical chart to show that the member/family has been offered peer support or family support, or there is evidence that a member requested to be connected to peer/family support and there is no evidence to show a referral was completed on behalf of the member/family.

General Clinical Chart (GCC-5): Service Time Frames

Requirements/Guidelines: There is evidence in the clinical chart that services recommended in the Service or Treatment Plan have been implemented within 45 days (*21 days for DCS/CHP members*). If there is even one instance of the service being added with the service not implemented within 45 days (21 days for DCS/CHP members), then this item shall be scored as a no. There should be evidence that the service has occurred within the time frame as demonstrated through progress notes, CFT, specialty provider communication or other documentation to reflect that the service has been implemented. A referral for a service is not sufficient evidence that the service has been implemented. If there has been no new service implemented within 45 days (21 days for DCS/CHP), documentation should reflect that new services have been implemented, or reasons for services not provided. This documentation may be counted as a yes.

Scoring:

Yes: Each time a service is newly added to the Service Plan there is evidence in the clinical chart that the service was implemented within 45 days; 21 days for DCS/CHP members.

No: Any service that has been added to the Service Plan that was not implemented within 45 days (21 days for DCS/CHP members). Adding the member to a waitlist or sending the referral, does not qualify as implementation.

General Clinical Chart (GCC-6): CALOCUS Assessment

Requirements/Guidelines: There is evidence within the clinical chart that the child has had a CALOCUS assessment.

The intent of this section is to ensure use of the CALOCUS by providers delivering services to children. Completion of the CALOCUS enables providers to identify the level of care and needed supports and services for the child. This may include a copy of the CALOCUS assessment or level of care score, if a CALOCUS has been completed by another service provider also working with the member. A CALOCUS assessment should be completed as part of the initial assessment and then every six months thereafter or more often, based on significant changes. If there is no evidence that a CALOCUS has been completed as part of the initial assessment, the rendering provider shall complete the CALOCUS, or collaboration should occur with a provider that can administer the CALOCUS.

Scoring:

Yes: There is evidence within the clinical chart that a CALOCUS has been completed for a child ranging in age from six to 18 years of age.

No: There is no CALOCUS that has been completed for a child ranging in age from six to 18 years of age.

N/A: The member is under the age of 6 or over the age of 18.

General Clinical Chart (GCC-7): High Needs Case Manager (HNCM)

Requirements/Guidelines: There is evidence within the clinical chart that if the child has a CALOCUS level of care, 4, 5, or 6, there is a high needs case manager assigned or there is documentation identifying why a high needs case manager is not assigned.

Scoring:

Yes: There is evidence that a HNCM has been assigned to a child with a CALOCUS level of 4, 5, or 6 or there is documentation why a HNCM is not assigned (e.g., option declined by parent/caregiver, health care decision maker).

No: There is no evidence that a HNCM was assigned to a child with a CALOCUS level of 4, 5, or 6 or no documentation identifying why a HNCM is not assigned.

N/A: This element is not applicable for children younger than six or older than 18 years of age, or for those children between six and 18 years of age, that have a CALOCUS level of 1, 2, or 3.

General Clinical Chart (GCC-8): Point of Contact for Member Coordination

Requirements/Guidelines: There is evidence within the clinical chart that the member was made aware of how to contact the provider responsible for coordinating, planning, and/or delivering services and support.

The intent of this section is to ensure that the member is aware of how to contact their provider responsible for coordination of care or service delivery (e.g., behavioral health case manager, ALTCS-EPD Case Manager or other primary point of contact responsible for coordinating, planning, and/or

delivering of services and support). For members that are ALTCS-EPD, this is the assigned ALTCS-EPD case manager under the ALTCS health plan. The contact information for the assigned ALTCS-EPD Case Manager is present should be identified within the clinical chart and there is documentation that the member is aware of how to contact the ATCS-EPD Case Manager.

Scoring:

Yes: There is evidence to indicate the member was made aware of how to contact the provider responsible for coordinating, planning, and/or delivering of services and support.

No: There is evidence to indicate the member was made aware of how to contact the provider responsible for coordinating, planning, and/or delivering of services and support.

General Clinical Chart (GCC-9): Collaboration

Requirements/Guidelines: There is evidence in the clinical chart that collaboration occurs across the delivery of care as other services or supports are identified to address member's needs.

The intent of this element covers various **activities** related to coordination of activities. Collaborative activities may include any or a combination of the following: (a) behavioral health providers for additional treatment or assistance with member needs and goals, (b) any health providers including the PCP, (c) other involved agencies as applicable (DCS, DES/DDD, ADJC, DOC). In instances when the member is new to the system, there may not be sufficient evidence of collaboration. Documentation that demonstrates the member being new to the system, as evidenced by reflection and initial assessment (including date), may be sufficient for a yes response.

Scoring:

Yes: There is evidence in the clinical chart of collaboration and coordination of care with other providers and/or systems or entities involved in the member's care.

No: There is no evidence to demonstrate collaboration and coordination of care with other providers and/or systems or entities involved in the member's care.

General Clinical Chart (GCC-10): Safety Planning

Requirements/Guidelines: There is evidence in the clinical chart that crisis or safety concerns have been assessed and if concerns or a crisis event were identified they were addressed in a crisis/safety plan, and coordinated as necessary across providers, based on needs identified within the crisis plan.

The intent of this element is to ensure that crisis and/or safety concerns identified through the delivery of services are addressed to maintain member and community safety. If there is documentation within the chart to indicate that member indicated no crisis or safety concern, or that they were not recently discharged from an inpatient setting, this documentation would qualify as evidence that the crisis safety concerns have been addressed.

Scoring:

Yes: There is evidence that any identified crisis safety concerns were addressed in a crisis/safety plan in the clinical chart.

No: There is no evidence that identified crisis safety concerns were addressed in a crisis/safety plan in the clinical chart.

General Clinical Chart (GCC-11): Engagement/Re-engagement

Requirements/Guidelines: There is evidence in the clinical chart of engagement or re-engagement after identification of a behavioral health crisis or safety concern.

The intent of this element is to identify the degree to which engagement and/or re-engagement occurred with a member after a behavioral health crisis or health safety concern, including discharge from inpatient services, notification of Emergency Room utilization, other changes in level of care, or to ensure member stabilization services are in place. Engagement shall occur with a member following discharge according to the discharge plan, but no later than seven days from the member's discharge from emergency department or inpatient setting. If a member has had involvement with the behavioral health crisis system, engagement is required within timeframes based on clinical need, but no later than 72 hours following crisis involvement. Engagement and/or re-engagement may include activities such as direct outreach and follow-up with the member to identify needed care, ensure member safety, and/or development of a crisis plan to prevent potential crisis situations from occurring (and as an approach for responding most effectively if one of these situations occurs). If there are multiple crisis or safety concerns identified within the clinical chart that have occurred within the audit review period, there should be evidence of engagement or re-engagement activities after each crisis or safety concern. If there is documentation to reflect that there has been no behavioral health crisis or safety concern, discharge from inpatient services, notification of Emergency Room utilization, or other changes in level of care during the review period, then this documentation would qualify as evidence that the crisis safety concerns have been addressed and would count as a yes.

Scoring:

Yes: There is evidence of engagement/reengagement activities after **each** behavioral health crisis or safety concern.

No: There is no evidence of engagement/reengagement activities after **each** behavioral health crisis or safety concern, discharge from inpatient services, notification of Emergency Room utilization, other changes in level of care. A "no" response is indicated if there is evidence of engagement/reengagement activities for only some, but not all of these events.

General Clinical Chart (GCC-12): Transition Age Youth (TAY)

Requirements/Guidelines: There is evidence in the clinical chart that transition activities begin no later than 16 years of age or upon initiation of services for anyone entering services over the age 16 and not yet 18 years of age.

The intent of this element is to ensure that youth receive timely assistance with transitioning to adulthood. Transition activities must begin no later than when a member turns 16 or if services are initiated after age 16, activities begin immediately. The CFT may determine that transition activities are needed prior to a member's 16th birthday and therefore they may begin earlier. The member may be referred to a provider specifically for assistance with the transition age youth process, with basic information about the benefits of receiving transition related services and support.

Scoring:

Yes: There is evidence that transition to adulthood activities began at 16 years of age or at initiation of services for anyone over the age of 16 and not yet 18 at the time-of-service initiation.

No: There is no evidence that transition to adulthood activities began by age 16 or that initiation of services for anyone over the age of 16 and not yet 18 at the time of service occurred.

N/A: Member is under the age of 16 during the review period or over the age of 18.

General Clinical Chart (GCC-13): SMI Determination

Requirements/Guidelines: There is evidence in the clinical chart that, if appropriate, the member has been referred for and/or offered an initial SMI Eligibility Determination and referred to the Determining Entity, or that the member/parent/HCDM has declined the option for an SMI Eligibility Determination.

The intent of the Serious Mental Illness (SMI) Eligibility Determination element is to ensure individuals receive a prompt and accurate referral to the Determining Entity, if a provider determines the need exists and/or if the member requests an SMI Eligibility Determination. If documentation indicates that a member or health care decision maker requests an SMI Eligibility Determination or if there is documentation regarding the need for an assessment, there must be evidence within the clinical chart that an SMI Eligibility Determination request has been submitted to the SMI Determining Entity. Members or Health Care Decision Makers can always decline an SMI Eligibility Determination and therefore credit will be given for documenting that a member or Health Care Decision Maker has declined the eligibility determination. For members aged 17 years and 6 months old with an SMI qualifying diagnosis, documentation will be present in the clinical record to demonstrate that an SMI Eligibility Determination was offered. If the member already has an SMI designation, that may be included under the N/A response.

Scoring:

Yes: There is evidence that the member received an SMI Eligibility Determination if determined clinically necessary and/or requested by the member or that the Eligibility Determination was declined by the member or health care decision maker.

No: There is evidence that an SMI Eligibility Determination was not offered or referred to the Determining Entity when identified as necessary and/or requested by the member and there is no documentation that the member or health care decision maker declined the eligibility determination.

N/A: Member is under the age of 17 years and 6 months old OR, documentation reflected that an SMI eligibility determination was not necessary or appropriate.

General Clinical Chart (GCC-14): Special Assistance/SMI Designation

Requirements/Guidelines: There is evidence in the clinical chart to indicate members with a serious mental illness (SMI) designation have been assessed for Special Assistance.

Documentation should reflect consistency related to the provider's assessment of whether the member did or did not require special assistance (e.g., information on the assessment, treatment plan, face sheet and/or other documentation). Special assistance is a support, rather than a treatment or a service. Members do not need to agree to receiving special assistance. A member may appeal the outcome of the special assistance assessment, unless they have a full/permanent HCDM, in which case the member meets criteria automatically. For members receiving special assistance (without an HCDM), they should be reassessed on a regular basis to ensure they continue to meet criteria for special assistance. Documentation related to special assistance should reflect that the member was assessed, who will meet the needs and if the member agrees.

Scoring:

Yes: There is evidence that the member with an SMI designation was assessed for meeting criteria for Special Assistance.

No: There is no evidence to indicate the member was assessed for meeting criteria for Special Assistance.

N/A: This element may be scored as N/A if the member does not have an "SMI designation".

General Clinical Chart-(GCC-15): Impact of Service Planning

Requirements/Guidelines: There is evidence within the clinical chart that services are continually evaluated with the member/family to ensure there is progress with the member in meeting goals.

The intent of this element is to ensure that Service Plan progress reviews are occurring with the member/family. The provider and member/family have reviewed progress in meeting the goals identified on the Service Plan. If necessary, adjustments are made to the Service Plan to reflect the effectiveness of interventions accordingly. If services have not been implemented, there should be

documentation to specify as to why services were not implemented, and necessary corrective action to have identified services take place. Barriers to progress in meeting goals should be discussed with the member/family and documented. The reviewer shall consider whether the services adequately addressed crisis; reduced placement disruptions and placements in a more restrictive level of care, reduced symptoms, improved educational progress, and promoted normal and natural childhood development (if applicable).

Scoring:

Yes: There is evidence of documentation in the clinical chart to reflect discussions with the member/family regarding progress to meeting goals.

No: There is no evidence in the clinical chart to reflect discussions with the member/family regarding progress in meeting goals.

CULTURAL COMPETENCY REQUIRED ELEMENTS AND GUIDELINES

Culture is defined as an integrated pattern of human behavior which includes but is not limited to—thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social, or political group; the ability to transmit the above to succeeding generations; dynamic in nature. All components of the clinical chart should reflect the culture and identity of the member or child and family or HCDM (e.g., race, and ethnic background, national origin, color, sex, sexual orientation, gender identity or expression, age marital status, political belief, religion, immigration status, and mental or physical ability). Cultural preferences of the member are honored in the Service Plan, and may also be addressed within the CFT or ART. The member’s preferences should be identified to further customize treatment to his/her unique cultures, faith, traditions, and priorities. Preferences about behavioral health services relating to spiritual beliefs or any other factors (e.g., provider gender preference, utilization of alternative medicine or traditional healer, sexual orientation) should be documented in the clinical chart. Merely listing a member’s strengths outside the context of a cultural description does not reflect cultural preferences. The ethnic, racial, familial, regional, or spiritual culture in which individuals reside help define their sense of their world, and their way of thinking, feeling, and responding. An effective portrait of a member and a successful Service Plan cannot be developed without exploring these factors. Barriers to effective communication, to treatment compliance and to feelings of engagement and respect can be addressed immediately, before they undermine service provision. Attention should be paid to how the member/family interprets their own culture, religion, family practices and/or adherence to specific beliefs and/or traditions. This serves to assist in identifying additional external strengths that may be available and useful in the service planning process.

Cultural Competency Requirements/Guidelines and Scoring:**Cultural Competency (CC-1): Cultural Customs/Values/Beliefs/Structure**

Requirements/Guidelines: There is evidence in the clinical chart that demonstrates the provision of culturally informed services that recognizes the member/family as an expert of their own culture.

The intent of this element is to identify that the member's cultural preferences are documented within the assessment, service plan, Strengths, Needs and Cultural Discovery, and CFT or ART.

Scoring:

Yes: There is evidence that the member's or family's cultural preferences were assessed, considered, and incorporated into the member's treatment recommendations.

No: There is no evidence to indicate that the member's or family's cultural preferences were assessed, but not incorporated into the treatment/service plan.

Cultural Competency (CC-2): Preferred Language-Oral

Requirements/Guidelines: There is evidence in the clinical chart that service providers assessed the need for qualified interpretation services to communicate (oral) in the preferred language of the member or child and family or healthcare decision maker, if applicable, and provided the service if indicated as a need (e.g., bilingual staff interpreters, contract interpreters, telephone interpreter lines, etc.).

Scoring:

Yes: There is evidence in the clinical chart to support that the member was asked their preferred language and that services were interpreted in the member's preferred language.

No: There is no evidence that the member was asked their preferred language or that the services were interpreted in the preferred language indicated by the member.

Cultural Competency (CC-3): Preferred Language-Written

Requirements/Guidelines: There is evidence in the clinical chart that service providers assessed the need for qualified translation services to communicate (written) in the preferred language of the member or child and family or health care decision maker, if applicable, and provided the service if indicated as a need (e.g., bilingual staff, staff translators, contract translators, etc.).

Scoring:

Yes: There is evidence in the clinical chart to support that the member was asked their preferred language for their clinical chart documentation and that documentation is translated in the preferred language indicated by the member.

No: There is no indication that the member was asked about their preferred language for clinical chart documentation or no indication that the clinical chart documentation has been translated into the preferred language indicated by the member.