

# **INSTRUCTION GUIDE FOR THE BEHAVIORAL HEALTH CLINICAL CHART AUDIT**

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# Instruction Guide for the Behavioral Health Clinical Chart Audit

## TABLE OF CONTENTS

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

# Instruction Guide for the Behavioral Health Clinical Chart Audit

GENERAL CLINICAL CHART REQUIRED ELEMENTS AND GUIDELINES.....	23
General Clinical Chart (GCC-1): Review of Services Options (Voice and Choice).....	23
General Clinical Chart (GCC-2): Natural Supports.....	23
General Clinical Chart (GCC-3): Participation of Others.....	24
General Clinical Chart (GCC-4): Peer Support; Family Support.....	24
General Clinical Chart (GCC-5): Service Time Frames.....	24
General Clinical Chart (GCC-6): CALOCUS Assessment.....	25
General Clinical Chart (GCC-7): High Needs Case Manager.....	25
General Clinical Chart (GCC-8): Point of Contact for Member Coordination.....	26
General Clinical Chart (GCC-9): Collaboration.....	26
General Clinical Chart (GCC-10): Safety Planning.....	27
General Clinical Chart (GCC-11): Engagement/Re-engagement.....	27
General Clinical Chart (GCC-12): Transition Age Youth.....	28
General Clinical Chart (GCC-13): SED Determination.....	28
General Clinical Chart (GCC-14): SMI Determination.....	29
General Clinical Chart (GCC-15): Special Assistance/SMI Designation.....	30
General Clinical Chart-(GCC-16): Impact of Service Planning.....	30
CULTURAL COMPETENCY REQUIRED ELEMENTS AND GUIDELINES.....	31
Cultural Competency (CC-1): Cultural Customs/Values/Beliefs/Structure.....	31
Cultural Competency (CC-2): Preferred Language-Oral.....	32
Cultural Competency (CC-3): Preferred Language-Written.....	32
DCS CHP SUPPLEMENTAL AUDIT ELEMENTS AND GUIDELINES.....	32
DCS CHP (DCS CHP-1): Crisis Effectiveness.....	33
DCS CHP (DCS CHP-2): Reduced Placement Disruptions and Reduced Placements in More Restrictive Levels of Care....	34
DCS CHP (DCS CHP-3): Symptom Reduction.....	35
DCS CHP (DCS CHP-4): Improvement in Educational Progress.....	36
DCS CHP (DCS CHP-5): Promotion of Natural Childhood Development.....	37
DCS CHP (DCS CHP-6): BHP Participation During CFT Practice.....	37
DCS CHP (DCS CHP-7): CFT Frequency.....	38
DCS CHP (DCS CHP-8): DCS Attendance at CFTs Provider Invitation.....	39
DCS CHP (DCS CHP-9): DCS Attendance at CFTs.....	39
DCS CHP (DCS CHP-10): Behavioral Health and Medical History.....	39
DCS CHP (DCS CHP-11): Integrated Rapid Response Referral for Initial BH Services-7 Days.....	40
DCS CHP (DCS CHP-12): Service Delivery Following Integrated Rapid Response.....	40
DCS CHP (DCS CHP-13): Service Planning Following Integrated Rapid Response.....	41

# Instruction Guide for the Behavioral Health Clinical Chart Audit

## 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 include but are not limited to those identified within the tables below:

AHCCCS Medical Policy Manual (AMPM)			
<b>AMPM 100</b>	Manual Overview	<b>AMPM 570</b>	Provider Case Management
<b>AMPM 310-B</b>	Title XIX XX1 Behavioral Health Services Benefit	<b>AMPM 580</b> (prior AMPM 220)	Child and Family Team
<b>AMPM 320-O</b>	Behavioral Health Assessments and Treatment Service Planning	<b>AMPM 583</b> (prior AMPM 240)	Family Involvement in the Children's Behavioral Health System
<b>AMPM 320-P</b>	Eligibility Determinations for Individuals with Serious Emotional Disturbance and Serious Mental Illness	<b>AMPM 584</b> (prior AMPM 250)	Youth Involvement in the Children's Behavioral Health System
<b>AMPM 320-Q</b>	General and Informed Consent	<b>AMPM 587</b> (prior AMPM 280)	Transition to Adulthood
<b>AMPM 320-R</b>	Special Assistance for Members with Serious Mental Illness	<b>AMPM 590</b>	Behavioral Health Crisis Services
<b>AMPM 320-U</b>	Pre-Petition Screening, Court Ordered Evaluation, and Court Ordered Treatment	<b>AMPM 910</b>	Quality Management/Performance Improvement Program Scope
<b>AMPM 520</b>	Member Transitions	<b>AMPM 940</b>	Medical Records and Communication of Clinical Information
<b>AMPM 541</b>	Coordination of Care with Other Government Agencies	<b>AMPM 1040</b>	Outreach, Engagement and Re-Engagement for Behavioral Health

AHCCCS Contractor Operations Manual	
<b>ACOM 404</b>	Contractor Website and Member Information
<b>ACOM 405</b>	Cultural Competency, Language Access Plan and Family-Member Centered Care
<b>ACOM 417</b>	Appointment Availability, Transportation Timeliness, Monitoring, and Reporting
<b>ACOM 449</b>	Behavioral Health Services for Children in Department of Child Safety (DCS) Custody and Adopted Children

Jason K. Settlement Final Agreement
Jason K. Settlement Agreement 2001

## Instruction Guide for the Behavioral Health Clinical Chart Audit

Jacob's Law
A.R.S. § 8-512.01
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)
Interagency Service Agreement
Arizona Health Care Cost Containment System and Arizona Department of Child Safety
YH22-0026 Contract Amendment DCS Supplemental Report

  

Arnold v. Sarn Stipulation
Arnold v. Sarn (January 8, 2014)

## 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 review a clinical chart using the Behavioral Health Clinical Audit Tool 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 used to score audit elements. A written request to AHCCCS is required for any recommendations for modifications to the instructions or methodology (discussed below), as identified in Section F, Attachment F3 Contractor Chart of Deliverables for Behavioral Health Clinical Chart Audit Methodology. All requests must be sent via email to [systemofcare@azahcccs.gov](mailto:systemofcare@azahcccs.gov). AHCCCS will review any request for revisions and if approved, will make revisions directly within the tool and/or instructions as applicable. AHCCCS will distribute updated versions of the instructions, methodology, or tool.**

The Clinical Chart Behavioral Health Audit tool is made up of five 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."

## Instruction Guide for the Behavioral Health Clinical Chart Audit

**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 Behavioral Health Clinical Chart 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 those needs 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, and/or (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 Health Care Decision Maker (HCDM), regard to 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.

**Section V:** The DCS CHP section is designed to include specific elements for utilization by DCS CHP to ensure compliance with B.K. ex rel. Tinsley, et al. v. Faust, et al., CV-15-00185-PHX-ROS (August 14, 2020).

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 or “null” and do not count for or against the total score. For any item scored N/A and thus null, remove 1 from the total allowable points on the audit tool.* Note: this is a change in logic from the original scoring guidelines as of the version dated September 6, 2023 (Version 4). Any element on its own shall **not** be used to validate or invalidate payment or medical necessity for services rendered, even if scored as “no.”

If the audit process identifies areas for improvement, health plans can choose to require corrective action as identified within AHCCCS policy and contract. The health plan may address corrective action based on audit section scores or individual elements, depending on the level of improvement needed. It is at the health plan’s discretion to determine the corrective action requirements that are needed to conform to AHCCCS policy and contract.

**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 a member declines the service or need, it shall be counted as a “yes” to satisfy scoring. If there is a lack of documentation to reflect the member’s declination, the element shall be scored as “no”.

**Sampling Methodology:** The Contractor shall conduct an audit of the behavioral health charts documenting the care provided to their members. The process shall be conducted to promote transparency and collaboration across health plans, providers, and community members.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

Member charts should be selected via a random sampling methodology that meets all required parameters outlined in the BHCCA requirements specific to populations served. In addition, member charts included in the audit should only include members who have been engaged with the provider for 90 days or greater to allow for timely development of the member-specific service plan. Contractors shall ensure that all network provider type 77 and IC providers who are identified within the Contractors network as a health home are included in the BHCCA provider list.

**Health home identification:** For the purpose of the BHCCA, include all Provider type 77 or IC providers contracted to provide behavioral health services as an assigned health home to all members who have an SMI designation, an SED designation, any child with a CALOCUS score of 4, 5 or 6, and all Health Homes providing services to adult and child GMH/SU members, including those providing Medication Assisted Treatment (MAT). All other behavioral health providers shall be monitored as specified in AMPM Policy 910. Provider sites who have been audited under the BHCCA are determined to have met the required monitoring as specified in AMPM Policy 910.

Sampling methodology shall be completed by assessing the Contractor's total population of members receiving behavioral health services from an assigned health home within the previous twelve months, including at minimum, any of the following service codes:

- Behavioral Health Assessment (e.g., 96160, 96161, H0031, 90791, H0001, H0031);
- Case Management (e.g., T1016, T1016-U1 [modifier for conducting CFT]);
- Therapy (e.g., 90832 - 90834, 90836-90838, 90846, 90847, 90849, 90853, H0004);
- Psychiatric Visits (e.g., 90887, 90889, 99202-99205, 99211-99215, 90791, 90792, 99341-99345, 99347-99350, 99441-99443, 99367);

Any combination of the services associated with the above codes shall have occurred within the most recent 12 months, as related to the date of the audit time frame, and for any provider type identified for audit inclusion.

Contractors shall ensure samples are based on a stratified random sampling methodology, which is statistically representative of the Contractor's total member population receiving services indicated above. If the Contractor has been awarded multiple contracts for more than one Line of Business (LOB), providers shall be selected based upon a representative sample size required per LOB. For each provider audited during the review cycle, the sample size is not to exceed an "n" of 30 charts per provider unless otherwise approved or directed by AHCCCS. In instances of a provider having less than 30 charts, the total number of clinical charts for that provider shall be included in the audit. Relative to the contractual relationship between the provider and Contractor conducting the audit, the final sample of providers to be audited shall be adjusted to meet minimum statistical significance.

DCS/CHP additional requirements: Provider sampling shall include all methodology listed above and shall also include a sufficient number of cases to achieve a 90% confidence level with a 10% margin of error. Sampling shall include charts representative of the subpopulations of children listed below:

- children having high needs case managers;
- children not having a high needs case managers; and
- children who have been placed with multiple caregivers

## Instruction Guide for the Behavioral Health Clinical Chart Audit

Audits shall be conducted according to the most current version of the Behavioral Health Clinical Chart Audit (BHCCA) Instruction Guide for the contract year and the corresponding BHCCA Audit Tool available on the [AHCCCS Integrated System of Care](#) (ISOC) webpage. The contractor shall utilize the AHCCCS Behavioral Health Audit portal for ongoing data input and analysis.

The audit process shall identify, at minimum, the following expectations:

- The extent to which the required audit elements are identified as meeting a threshold of 85% or above,
- The continuity between needs identified within the assessment and the service plan goals, objectives and services to be delivered,
- Identification of member needs that are met and unmet via the service plan goals and objectives, and
- Fulfillment of requirements identified within the Stipulation Agreement (B.K. ex rel. Tinsley, et al. v. Faust, et al., CV-15-00185-PHX-ROS) and dated August 14, 2020, as applicable to the DCS CHP identified Subcontractor.

The audit process shall result in as minimal a burden as reasonably possible to the behavioral health providers identified with the provider type designations below. All contracted behavioral health providers should be audited at least once every three years.

All provider types that are identified as either a health home or acting as the primary behavioral health provider shall be included in the random sampling if they offer provider the following:

- Assessments (i.e., comprehensive assessment/reassessment or other assessment activities such as ASAM, CALOCUS, etc.),
- Service planning that includes continuous monitoring of member progress,
- Case management,
- Coordination of care (including, but not limited to discharge planning, crisis follow-up),
- Outreach, engagement or re-engagement,
- Referral activities,

Contractors are to select 30 charts for review per provider service site. Contractors will ensure that samples are statistically representative of the health plan's total member population, representative of all applicable lines of business and geographical service areas (GSA) and that the 30 selected charts include only members for whom the provider service site location is acting as the assigned health home or the primary behavioral health provider. Compliance and document the final score for the provider site location based on the findings of the audit. Contractors shall ensure that all network provider type 77 and IC's who have provided any combination of the following services codes during the look back period are subject to the audit:

**Behavioral Health Assessment** (96160, 96161, H0031, 90791, H0001, H0031);

**Case Management** (T1016, T1016-U1 [modifier for conducting CFT]);

**Therapy** (90832 - 90834, 90836-90838, 90846, 90847, 90849, 90853, H0004);

**Psychiatric Visits** (90887, 90889, 99202-99205, 99211-99215, 90791, 90792, 99341-99345, 99347-99350, 99441-99443, 99367).

If the Contractor identifies a provider service site or a set of provider services sites that match these criteria but are not identified as a health home and are not acting as the members primary behavioral health provider, Contractors may submit a request to remove these providers from the provider list to be audited. Requests must

## Instruction Guide for the Behavioral Health Clinical Chart Audit

include a summary of the Contractor's data analysis that resulted in the provider service site(s) being pulled for audit and the rationale for determining that the provider service site was not subject to the audit.

As indicated above, requests for changes to the methodology must be sent via email to [systemofcare@azahcccs.gov](mailto:systemofcare@azahcccs.gov). Updated methodology shall be required 30 days prior to any changes, as indicated in Contract Section F, Attachment F3, Contractor Chart of Deliverables for CY2025.

### **Behavioral Health Clinical Chart Audit Findings Summary Report**

The reporting template includes the following section requirements:

1. Portal Data
2. Description of the Contractor's Narrative Description of Audit Process
3. Description of Members Included in the Audit
4. Summary of Findings and Trends
5. Exit Interview Process
6. Audit Process Strengths and Opportunities for Improvement
7. Provider Suspensions or Terminations

## ASSESSMENT COMPONENTS REQUIRED ELEMENTS AND GUIDELINES

This section is designed to evaluate elements within the most recent version of an assessment completed for a member. The assessment is designed to address a member's current needs and to allow for reassessments as needed (significant events, or changing needs as identified by the member), and 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, at a minimum, 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 member's needs as they relate to required assessment elements since the last assessment. Documentation should be provided if no changes are necessary to that element. No specific assessment forms are required if 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) or assessments from other providers with whom the member is working to best 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. Do not use N/A when an element cannot be scored because the assessment does not meet criteria based on lack of timeliness or Behavioral Health Professional (BHP) signature. There may also be evidence of assessment activity within other areas of clinical documentation that may satisfy individual assessment elements (e.g., General Clinical Chart section, CFT/ART notes, Case notes, etc.).

# Instruction Guide for the Behavioral Health Clinical Chart Audit

## Assessment Requirements/Guidelines and Scoring:

### Assessment (A-1): Assessment Completion

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

This element is not specific to an initial or comprehensive assessment 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 clinical chart that was completed within the 12-month timeframe, it shall not render the current/most recent assessment as invalid.

If an assessment has been completed by another provider within 12 months before the date of the patient's current admission, the patient's information shall be reviewed and updated. Documentation of the review and updated information shall be in the member's clinical chart within 48 hours after the review is completed. This assessment can serve to meet the needs of the A-1 completed assessment element, service planning, CFT, or ART activities until reassessments can be completed by the provider currently serving the member.

#### Scoring:

**Yes:** The assessment (either initial or reassessment) was conducted within the last 12 months.

**No:** The assessment (either initial or reassessment) was not conducted within the last 12 months.

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

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

The intent of this audit element 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), that 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 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 within the acceptable ADHS timeframe.

**No:** The assessment was **not** signed by BHP and/or was not signed within the acceptable ADHS timeframe.

### Assessment (A-3): Presenting Concerns

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

The intent of this element 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.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

**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 element 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 includes information about 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 (physical and behavioral health) of the member OR there is **no** documentation 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 element is considered assessed and will be given credit.

#### Scoring:

**Yes:** The assessment includes current/past medication information for physical and/or behavioral health needs OR there is documentation to reflect that information has been requested from other providers but has not yet been received.

**No:** The assessment does **not** include current/past medication information for physical and/or behavioral health needs OR there is **no** documentation to reflect 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

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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 includes identification of family history regarding physical and/or behavioral health needs, OR if family history has been gathered previously, there is documentation that identifies 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** documentation to reflect that this information was previously gathered or that there are no changes in family history.

### 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 element is to verify the assessor documents key elements of the member's social, emotional, and physical skill development. Developmental history shall be completed for all members participating in an assessment and 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 due to changes in physical or cognitive presentation and need and regardless of age.** If developmental history has been gathered previously, documentation should be present to indicate that there are no changes. If developmental history is not readily available within the current clinical chart, the auditor shall request verification of developmental history (or lack thereof) from the provider. This information may be gathered from the member, family member/caregiver, Department of Child Safety/Comprehensive Health Plan (DCS/CHP) or Department of Economic Security/Division of Developmental Disabilities (DES/DDD) staff, and/or DES/DDD group home, as applicable.

### Scoring:

- Yes:** Developmental history is included within the assessment, OR there is documentation to reflect 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:** Developmental history is **not** included within the assessment **and** there is **no** documentation to reflect that developmental history has been gathered previously or that there are no changes in developmental history.

### 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 element is to verify that a member's history of trauma (e.g., sexual abuse, domestic or interpersonal violence, community violence, neglect, natural disasters, victim of a crime, 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

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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:** Trauma history is addressed, as outlined above, within the assessment. Documentation exists to indicate that trauma history was obtained and evaluated previously, and/or clinical rationale identifies that trauma history does not need to be reexamined.
- No:** Trauma history was not addressed, as outlined above within the assessment OR documentation does not exist to indicate that trauma history was obtained and evaluated previously, and/or clinical rationale does not identify that trauma history does not need to be reexamined.

### 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 element 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, medical, physical, financial, or other exploitation.

### Scoring:

- Yes:** Risk of exploitation was assessed, OR documentation exists to indicate risk of exploitation was obtained and evaluated previously, and/or clinical rationale identifies the risk of exploitation does not need to be reexamined.
- No:** Risk of exploitation was **not** assessed **and** there is **no** documentation within the assessment to indicate the provider explored concerns surrounding exploitation **nor** is there a 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 element is to ensure potential substance use (as an adult and/or child) or childhood exposure to substances is identified. This may include the use of a standardized screening or assessment, which may include but is not limited to American Society of Addiction Medicine (ASAM) Criteria 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 in childhood. If current or past substance use 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.

### Scoring:

- Yes:** The member was screened for substance use and/or substance exposure in childhood.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

**No:** The member was **not** screened for substance use and/or substance exposure in childhood, or 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 element shall be scored as “no”.

### 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 availability, transportation, safety/access to weapons or firearms, etc.).*

The intent of this element is to ensure the assessor has identified the 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:** The member was assessed for needs related to the living environment/situation.

**No:** The member was **not** assessed for needs related to the living environment/situation.

### 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 element 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 member-reported 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 accesses 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 support by choice as opposed to not having/identifying any social support. 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:** The member was assessed for needs related to availability of social support, level of isolation or reported loneliness, etc., regardless of whether the member is a child or an adult.

**No:** The member was **not** assessed for needs related to availability of social support, level of isolation, loneliness, etc., regardless of whether the member is a child or an adult.

### 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 element 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

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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:** The member was 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, based on clinical judgment or member request.
- No:** The member was **not** assessed for needs related to education and/or vocational training, OR there is **no** documentation to reflect that the member did not have/identify any education or vocational needs, OR that it was deemed not appropriate at time of assessment, based on clinical judgment.

### Assessment (A-14): Employment

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

The intent of this element is to ensure the assessor collected enough information to gain an understanding of the member's employment, 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:** The member was assessed for needs related to employment.
- No:** The member was **not** assessed for needs related to employment.
- N/A:** Acceptable only 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 element is to ensure the assessor has evaluated the member's awareness of and access to, and utilization of or ability to utilize 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:** The member was assessed for knowledge of and utilization of public or private resources (e.g., cash assistance, food stamps, childcare, etc.) that are available to support member needs.
- No:** The member was **not** assessed for knowledge of and utilization of public or private resources (e.g., cash assistance, food stamps, childcare, etc.) that are available to support member needs.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

### Assessment (A-16): Involvement of Health Care Decision Maker (HCDM), Guardian, and/or Conservator

**Requirements/Guidelines:** *There is evidence that the assessor determined the presence or absence of a health care decision maker, guardian or conservator.*

The intent of the HCDM section is to ensure the assessor has identified if an HCDM exists and if they do, to include their involvement in behavioral health services. For adults, having an HCDM, guardian, or conservator may indicate the limited capacity of the adult to engage in or consent to services, which should be explored. For children, if their identified parent is not included in care, the nature of the HCDM should be identified. With children, this may be an indicator that the Arizona Department of Child Safety (DCS) and/or Tribal Social Services specific to a child's tribal community is the legal entity. Legal documentation shall be included within the clinical chart if there is HCDM involvement in place.

#### Scoring:

**Yes:** The assessor determined the presence or absence of an HCDM, guardian, or conservator.

**No:** The assessor did **not** determine the presence or absence of an HCDM, guardian, or conservator.

### Assessment (A-17): COE/COT Involvement

**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 the 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 and/or PAD/GAD), or are currently under a court order for treatment, are identified. For individuals who meet the criteria for a court ordered evaluation, documentation must also show that the member has been referred to an appropriate screening agency.

#### Scoring:

**Yes:** The assessor determined the presence of a court order and has requested/obtained a copy of the court order or that a need has been identified for a court ordered evaluation, and the screening agency has been notified, OR there is documentation to reflect that the member is not court ordered to treatment or does not need a referral for a screening for a court ordered evaluation.

**No:** The assessor did **not** determine the presence of a court order or the need for a court ordered evaluation, **and** there is **no** documentation to reflect that the member is not court ordered to treatment or does not need a referral for a screening for a court ordered evaluation.

**N/A:** N/A is acceptable for children **less than** 18 years old.

### 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 element 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

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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 support that may be used in the initial service planning process.

### Scoring:

**Yes:** The member's current and past criminal justice involvement (e.g., either as a defendant/respondent or victim/plaintiff) was addressed through the assessment process.

**No:** The member's current and past criminal justice involvement (e.g., either as a defendant/respondent or victim/plaintiff) was **not** 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 due to an inability to communicate. 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), or (d) an Arizona Superior Court has made the member a ward of the state and identified a person or public/private fiduciary as their legal guardian.

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:** The member's needs were assessed for necessary communication capabilities (special accommodations for hearing, vision, cognitive, language interpretation, etc.).

**No:** The member's needs were **not** 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) to ensure their safety. 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 or changes in physical or cognitive functioning. 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

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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 a risk assessment within the clinical chart.

**No:** There is **no** risk assessment within 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. An MSE 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.

### Scoring:

**Yes:** There is a Mental Status Exam included within the clinical chart and/or there is documentation that a MSE cannot be completed due to a member's age, symptomology, and/or physical or behavioral health functioning.

**No:** There is **no** Mental Status Exam included within the clinical chart and no documentation about why the MSE could not be completed.

### 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 shall also include evidence of the member's history, presentation, symptomology, and other factors demonstrating support for the diagnosis along with other diagnostic factors such as the medical condition of the person.

### Scoring:

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

**No:** There is **no** diagnostic impression and an assigned diagnosis 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 (HCDM) 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. If the member has a court order for treatment, the requirements of that order are also integrated into the service plan along with the member's identified goals. The service plan should follow a strengths-based approach and encourage the development of

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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 shall establish the member's desired outcomes anytime throughout the course of treatment. During subsequent reviews, the service plan shall be updated to reflect progress toward achieving the member's desired outcomes. Additionally, the service plan elements shall be used as a method for checking in with the member, parent, and/or caregiver to discuss what changes may have occurred for the member relative to those service plan needs, since the most recent assessment, CFT, or ART. It is important to identify and address changing member needs so that they can be addressed through the service plan without having to delay care due to the need to conduct a complete reassessment.

### 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 shall be updated in conjunction with the most recent assessment to incorporate additional updates to ensure the member's needs are met throughout the service time frame as indicated on the service plan. 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:** A service plan was completed within the last year, and it was updated in conjunction with the most recent assessment.
- No:** The service plan in the clinical chart is **more than** 1 year old, OR 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 health care decision maker and that the provider obtained either verbal or written consent, indicating agreement with the goals and services outlined in the service plan.*

#### Scoring:

- Yes:** 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:** Verbal or written consent was **not** obtained from the member or HCDM that indicates agreement with the service plan.

# Instruction Guide for the Behavioral Health Clinical Chart Audit

## 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:** The service plan was completed and signed by a BHP OR it was completed by a BHT/BHPP, reviewed and signed by a BHP.
- No:** The service plan was **not** completed and signed by a BHP OR it was completed by a BHT/BHPP, but **NOT** signed by a BHP.

## 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, safety/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), not just at the time of an assessment, but more frequently if needed to ensure member's needs are met. The 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 shall be documented related to the assessor's attempts to engage the member in addressing the living environment if identified as a concern/issue. If securing a safe and appropriate living environment was identified as a need, the assessor shall include this as a priority for service planning discussion.

### Scoring:

- Yes:** The service plan addresses the needs identified in the assessment related to living environment/situation, OR the member indicated there was not a need related to living environment/situation, OR there is documentation that the member declined to include a goal for living environment, even if it was identified as a need within the assessment.
- No:** The service plan does **not** address the needs identified in the assessment related to living environment/situation, OR there is **no** documentation to reflect that there was not a need related to living environment/situation, OR there is **no** documentation that the member declined to include a goal for living environment/situation, even if it was identified as a need within the assessment.

## 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).*

The intent of this element is to ensure the member is assessed for needs related to socialization. Social supports have been shown to influence the member's quality of life; whereas isolation and loneliness have been correlated with poor health outcomes. Member's ability to achieve their service plan goals may be influenced by

## Instruction Guide for the Behavioral Health Clinical Chart Audit

levels of social and natural support systems. During the service planning process, the member may decline to include a goal related to social supports. Efforts shall be documented related to the assessor's attempts to engage the member in addressing these needs. If the member expresses a desire to increase levels of social support or reduce loneliness and isolation, the assessor shall include this as a priority for service planning discussion.

### Scoring:

- Yes:** The service plan addresses the needs identified in the assessment related to socialization, OR the member indicated there was not a need related to socialization, OR there is documentation that the member declined to include a goal for socialization, even if it was identified as a need within the assessment.
- No:** The service plan does **not** address the needs identified in the assessment related to socialization, OR there is **no** documentation to reflect that there was not a need related to socialization, OR there is **no** documentation that the member declined to include a goal for socialization, even if it was identified as a need within the assessment.

### 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, or more frequently if needed to ensure member's needs are met.

### Scoring:

- Yes:** The service plan addresses the needs identified in the assessment related to Educational and/or Vocational Training, OR the member indicated there was not a need related to Educational and/or Vocational Training, OR there is documentation that the member declined to include a goal for Educational and/or Vocational Training, even if it was identified as a need within the assessment.
- No:** The service plan does **not** address the needs identified in the assessment related to Educational and/or Vocational Training, OR there is **no** documentation to reflect that there was not a need related to Educational and/or Vocational Training, OR there is **no** documentation that the member declined to include a goal for Educational and/or Vocational Training, even if it was identified as a need within the assessment.

### 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, or more frequently if needed to ensure member's needs are met.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

### Scoring:

- Yes:** The service plan addresses the needs identified in the assessment related to employment, OR the member indicated there was not a need related to employment, OR there is documentation that the member declined to include a goal for employment, even if it was identified as a need within the assessment.
- No:** The service plan does **not** address the needs identified in the assessment related to employment, OR there is **no** documentation to reflect that there was not a need related to employment, OR there is **no** documentation that the member declined to include a goal for employment, even if it was identified as a need within the assessment.
- 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 shall provide a description of how the member would like their life, family, and environment to be once services are no longer needed.

### Scoring:

- Yes:** The service plan goals are based on the member/family vision.
- No:** 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:** The goals on the service plan utilize the member and/or family strengths identified in the assessment and service planning process.
- No:** 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 services, and/or medical documentation from other providers, and any other information related to member needs, delivery, and coordination of services.

# Instruction Guide for the Behavioral Health Clinical Chart Audit

## 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 shall 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 shall indicate discussion of member voice and choice of service providers. The concept of member voice and choice involves more than sharing the member handbook, which is already a required activity under contract.

#### Scoring:

**Yes:** The member was given provider options and the opportunity to accept or decline specific providers (voice and choice).

**No:** The member was **not** given provider options or the opportunity to accept or decline specific providers (voice and choice).

### 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 support may include family members, friends, faith-based community support 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:** The provider discussed and assisted the member/family in identifying informal or natural supports.

**No:** The provider did **not** discuss and assist the member/family in identifying informal or natural supports.

### 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 people, but it is not a requirement. Designated representatives, agency representatives, and

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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:** The member/family was given the opportunity to include other individuals in the service planning.

**No:** The member/family was **not** 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 element 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:** The member/family has been informed of and offered peer support or family support services or the member requested to be connected to peer/family support, and referral was completed on behalf of the member/family.

**No:** The member/family has **not** been informed of and offered peer support or family support services, OR the member requested to be connected to peer/family support services, but no 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).*

There shall 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.

### Scoring:

**Yes:** Any time a service was added to the service plan, there is documentation to reflect the service was implemented within 45 days (21 days for DCS/CHP members) OR there is documentation that no new services have been implemented within and **no later than** 45 days (21 days for DCS/CHP) OR reasons that services were not provided, then this element shall be scored as a "yes".

**No:** Any time a new service was added to the service plan, but there is **no** documentation to reflect that the service was implemented within 45 days (21 days for DCS/CHP members), OR there is **no** documentation to reflect that no new services were added. If there is even one instance of the service being added with the service plan and not implemented within 45 days (21 days for DCS/CHP members), then this element

## Instruction Guide for the Behavioral Health Clinical Chart Audit

shall be scored as a “No”. Adding the member to a waitlist or sending the referral, does not qualify as implementation and shall be scored as a “No”.

### 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 CALOCUS shall be used for children receiving behavioral health services. Completion of the CALOCUS enables providers to identify the level of care and needed support and services for the child. This may include a copy of the CALOCUS or level of care score, if a CALOCUS has been completed by another service provider also working with the member. A CALOCUS shall 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:** The CALOCUS has been completed for a child ranging from six years to 18 years of age.
- No:** The CALOCUS has **not** been completed for a child ranging from six years to 18 years of age.
- N/A:** May only be scored as N/A if the member is under the age of six or over the age of 18.

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

**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:** An HNCM has been assigned to a child with a CALOCUS level of 4, 5, or 6, OR there is documentation to indicate why an HNCM is not assigned (e.g., option declined by parent/caregiver, health care decision maker).
- No:** An HNCM was **not** assigned to a child with a CALOCUS level of 4, 5, or 6 **and** there is **no** documentation to indicate why an HNCM is not assigned. *Documentation to reflect a lack of available case managers would not be an allowable reason for a child not being assigned to an HNCM and would count as a no.*
- N/A:** May only be scored as N/A if the member is 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

## Instruction Guide for the Behavioral Health Clinical Chart Audit

contact information for the assigned ALTCS-EPD Case Manager is present and should be identified within the clinical chart. There is documentation that the member is aware of how to contact the ATCS-EPD Case Manager.

### Scoring:

**Yes:** There is documentation within the clinical chart to demonstrate that the member was made aware of how to contact the provider responsible for coordinating, planning, and/or delivery of services and support.

**No:** There is documentation within the clinical chart to demonstrate that the member was **not** made aware of how to contact the provider responsible for coordinating, planning, and/or delivery 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, and/or (c) other involved agencies as applicable (DCS, DES/DDD, ADJC, ADCRR, etc.). 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 documentation within the clinical chart to demonstrate collaboration and coordination of care with other providers and/or systems or entities involved in the member's care, OR that the member has indicated they do not want collaboration with other providers to take place.

**No:** There is **no** documentation within the clinical chart to demonstrate collaboration and coordination of care with other providers and/or systems or entities involved in the member's care, OR that the member has indicated they do not want collaboration with other providers to take place.

### 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 or clinical indicators, are addressed to maintain member and community safety.

### Scoring:

**Yes:** Identified crisis and/or safety concerns were addressed in a crisis/safety plan in the clinical chart. If there is documentation within the chart to indicate that the member indicated no crisis or safety

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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 and element scored as “yes”.

**No:** Identified crisis and/or safety concerns were **not** addressed in a crisis/safety plan in the clinical chart. If there is **no** documentation within the chart to indicate that the member indicated no crisis or safety concern, or no documentation to reflect that they were not recently discharged from an inpatient setting, the member’s crisis/safety concerns have **not** been addressed and the element shall be scored as a no.

### 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 the 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 crises 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.

#### Scoring:

**Yes:** Engagement/reengagement activities occurred after **each** behavioral health crisis or safety concern, discharge from inpatient services, notification of emergency room utilization, or other changes in level of care, OR there is documentation that the member has not had a recent crisis event or safety concern within the review period, then this element would be scored as a yes.

**No:** **No** engagement/reengagement activities occurred after **each** behavioral health crisis or safety concern, discharge from inpatient services, notification of emergency room utilization, or other changes in level of care. For instance, if a member was hospitalized three times but follow-up was documented only two times, or there is no documentation that the member has not had a recent crisis event or safety concern, this element would be scored as a no.

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

**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.*

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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 16<sup>th</sup> 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:** 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:** Transition to adulthood activities did **not** begin by age 16 or at initiation of services for anyone over the age of 16 and not yet 18 at the time of service occurred.
- N/A:** May **only** be scored as N/A if the member is under the age of 16 during the review period or over the age of 18.

### General Clinical Chart (GCC-13): SED Determination

**Requirements/Guidelines:** *There is evidence in the clinical chart that, the member has been referred for and/or offered an initial SED Eligibility Determination and referred to the Determining Entity, or that the member/HCDM has declined the option for an SED Eligibility Determination, or there is documentation that an SED Eligibility Determination was not necessary based on diagnosis or functional limitations.*

The intent of the Serious Emotional Disturbance (SED) Eligibility Determination element is to ensure children receive a prompt and accurate referral to the Determining Entity, if a provider determines the need exists and/or if the health care decision maker (HCDM) requests an SED Eligibility Determination. If documentation indicates that a member's HCDM requests an SED Eligibility Determination or if there is documentation regarding the need for an assessment, there must be evidence within the clinical chart that an SED Eligibility Determination request has been submitted to the Determining Entity. Member's HCDM can always decline an SED Eligibility Determination and therefore credit will be given for documenting that the HCDM has declined the eligibility determination. For members under 18 years of age, the qualifying diagnosis documentation will be present in the clinical record to demonstrate that an SED Eligibility Determination was offered.

### Scoring:

- Yes:** The member has been referred for and/or offered an initial SED Eligibility Determination and referred to the Determining Entity, or the member/HCDM has declined the option for an SED Eligibility Determination, or there is documentation that an SED Eligibility Determination was not necessary based on diagnosis or functional limitations.
- No:** The member was **not** referred for and/or offered an initial SED Eligibility Determination and referred to the Determining Entity, or the member/HCDM declined the option for an SED Eligibility Determination, there is no documentation that an SED Eligibility Determination was not necessary based on diagnosis or functional limitations.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

**N/A:** May **only** be scored as N/A if the member is over the age of 18 years of age OR member already has an SED designation.

### General Clinical Chart (GCC-14): SMI Determination

**Requirements/Guidelines:** *There is evidence in the clinical chart that the member has been referred for and/or offered an initial SMI Eligibility Determination and referred to the Determining Entity, or that the member/HCDM has declined the option for an SMI Eligibility Determination, or there is documentation that an SMI Eligibility Determination was not necessary based on diagnosis or functional limitations.*

The intent of the Serious Mental Illness (SMI) Eligibility Designation 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 Designation Determination. If documentation indicates that a member or HCDM requests an SMI Eligibility Designation or if there is documentation regarding the need for an assessment, there must be evidence within the clinical chart that an SMI Eligibility Designation request has been submitted to the SMI Determining Entity. Members or Health Care Decision Makers can always decline an SMI Eligibility Designation and therefore credit will be given for documenting that a member or HCDM 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 Designation Determination was offered.

#### Scoring:

**Yes:** The member has been referred for and/or offered an initial SMI Eligibility Determination and referred to the Determining Entity, or the member/HCDM has declined the option for an SMI Eligibility Determination, OR there is documentation that an SMI Eligibility Determination was not necessary based on diagnosis or functional limitations.

**No:** The member was **not** referred for and/or offered an initial SMI Eligibility Determination and referred to the Determining Entity, or the member/HCDM declined the option for an SMI Eligibility Determination, OR there is no documentation that an SMI Eligibility Determination was not necessary based on diagnosis or functional limitations.

**N/A:** May **only** be scored as N/A if the member is under the age of 17 years and 6 months old OR member already has an SMI designation.

### General Clinical Chart (GCC-15): 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 shall reflect consistency related to the provider's assessment of whether the member did or did not require or request 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 Special Assistance services. For members receiving special assistance (without an HCDM), they shall be

## Instruction Guide for the Behavioral Health Clinical Chart Audit

reassessed on a regular basis to ensure they continue to meet criteria for special assistance. Documentation related to special assistance shall reflect that the member was assessed, who will meet the needs and if the member agrees.

### Scoring:

- Yes:** The member with an SMI designation was assessed for meeting criteria for Special Assistance, regardless of the outcome.
- No:** The member with an SMI designation was **not** assessed for meeting criteria for Special Assistance.
- N/A:** May **only** be scored as N/A if the member does not have an SMI designation.

### General Clinical Chart-(GCC-16): 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 shall be documentation to specify as to why services were not implemented, and necessary corrective action to ensure that identified services take place to meet member needs. Barriers to progress in meeting goals shall be discussed with the member/family and documented. The reviewer shall consider whether the services adequately addressed needs identified by the member/family (e.g., crisis; meeting needs related to social determinants, trauma, symptom reduction, substance use, reduced placement disruptions and placements in a more restrictive level of care, improved educational progress, and promoted normal and natural childhood development).

### Scoring:

- Yes:** There is documentation in the clinical chart to reflect discussions with the member/family regarding progress toward meeting goals.
- No:** There is **no** documentation in the clinical chart to reflect discussions with the member/family regarding progress toward 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 shall 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 shall be identified to

## Instruction Guide for the Behavioral Health Clinical Chart Audit

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) shall 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 helps 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 recognize 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:** The member's or family's cultural preferences were assessed, considered, and incorporated into the member's treatment recommendations.

**No:** The member's or family's cultural preferences were **not** assessed, **or** if assessed, were **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/family and provided the service if indicated as a need (e.g., bilingual staff, staff interpreters, contract interpreters, telephone interpreter lines, etc.).*

#### Scoring:

**Yes:** The member/family was asked their preferred language and there is evidence in the clinical chart to reflect that qualified interpretation services were provided in the member's preferred language.

**No:** The member was either **not** asked their preferred language or there is **no** evidence in the clinical chart to reflect that qualified interpretation services were provided in the member's preferred language.

# Instruction Guide for the Behavioral Health Clinical Chart Audit

## 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/family and provided the service if indicated as a need (e.g., bilingual staff, staff translators, contract translators, etc.).*

### Scoring:

- Yes:** The member/family was asked their preferred language and there is evidence in the clinical chart to reflect that qualified interpretation services were provided in the member's preferred language.
- No:** The member was either **not** asked their preferred language or there is **no** evidence in the clinical chart to reflect that qualified interpretation services were provided in the member's preferred language.

## DCS CHP SUPPLEMENTAL AUDIT ELEMENTS AND GUIDELINES

DCS, with support from any subcontracted Managed Care Organization, and as part of its larger Quality Management System, shall conduct the Behavioral Health Clinical Chart Audit to meet requirements set forth in AHCCCS Contract and Policy. DCS shall also meet the stipulations set forth within B.K. ex rel. Tinsley, et al. v. Faust, et al., CV-15-00185-PHX-ROS (August 14, 2020), the particular needs of children in foster care are met as identified:

- (1) Whether the behavioral health assessments, evaluations, service plans, and CFTs for Class Members during the period under review were conducted in compliance with measurements as defined in the Clinical Chart Audit tool.
- (2) Whether the Class Members during the period under review, received the services identified in, and in the timeframe contemplated by, their behavioral health service plans.
- (3) Whether the behavioral health services received by Class Members during the period under review were effective.

Within AHCCCS Policy ACOM 449, Integrated Rapid Response (IRR) is defined as *a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is referred and then dispatched within 72 hours to assess a child's immediate physical and behavioral health needs and to refer the child for additional assessments through the behavioral health system.*

- If the reviewer determines that Integrated Rapid Response did not occur as required or occurred with a previous provider that is not being audited, reviewer will use initial assessment and service plan at the time the member was opened with the provider that is being audited to evaluate timeliness of Integrated Rapid Response elements below. The reviewer will review the complete clinical chart of the member as needed for audit completion.

As it relates to sampling of DCS CHP members and the look back period for collection, DCS CHP shall provide documentation within their BHCCA Findings and Summary Report of the following:

- Criteria and process for how the sample is pulled that includes how the subpopulations' cases are pulled:

## Instruction Guide for the Behavioral Health Clinical Chart Audit

- Indicate sufficient number of cases to achieve 90% confidence level with a 10% margin of error
- Include subpopulation of children with the following:
  - Children having high needs case managers
  - Children not having high needs case managers
  - Children who have been placed with multiple caregivers
- Reviewers shall follow due diligence steps to ensure that if a child is pulled for the audit sample that does not meet the above criteria, that a replacement case be identified for a child that does meet the criteria.
- If a sampled child's Integrated Rapid Response occurred more than 12 months ago, the reviewer will also need to evaluate the first 120 days following the Integrated Rapid Response to answer questions specific to meeting required timelines.

### DCS CHP Requirements/Guidelines and Scoring:

#### DCS CHP (DCS CHP-1): Crisis Effectiveness

**Requirements/Guidelines:** *There is evidence in the clinical chart that services provided to the member were effective in addressing crisis.*

The reviewer is to evaluate whether the services provided to the child were effective in addressing crises. If the child did not experience a crisis during the review period, the reviewers are to evaluate if clinically appropriate services and support provided to the child were effective at preventing a crisis event. Reviewers should also consider if a safety plan is present within the clinical chart and if the child has been given appropriate support to use the preventative measures outlined in the safety plan to effectively prevent a crisis. If a child experienced a crisis during the review period, the reviewer should look for whether the crisis was responded to immediately and whether the intervention and disposition were appropriate given the identified needs of the child. Crisis mobile response and subsequent follow-up in the first 24 hours following a crisis call are the responsibility of the ACC-RBHA. The reviewer should also consider whether the provider took appropriate follow-up action, post-crisis intervention including the following:

- Outreach to the child and family within a timeframe that meets clinical need,
- Modification to the crisis plan to address newly identified needs and prevent future crisis episodes within 72 hours,
- Modification to the services plan to address newly identified needs and additional services/supports implemented as determined necessary by the Child and Family Team.
- Re-evaluation of service intensity including the completion of the CALOCUS, and
- Prevent further escalation unless determined necessary, such as placement disruption, police intervention, hospitalization, mobile team, etc.

### Scoring:

**Yes:** The clinical chart includes sufficient documentation indicating services provided to the member were effective in addressing crises. The member received clinically appropriate services and therefore did not

## Instruction Guide for the Behavioral Health Clinical Chart Audit

experience a crisis. The member had an effective safety plan that prevented crisis OR any crisis event that occurred was responded to effectively to prevent future crisis.

**No:** The clinical chart does **not** include sufficient documentation indicating services provided to the member were effective in addressing crises. The member experienced a crisis and services on the member's service plan were not being provided or were not effective. The member experienced a crisis and appropriate follow up actions did **not** occur to prevent future crises.

### DCS CHP (DCS CHP-2): Reduced Placement Disruptions and Reduced Placements in More Restrictive Levels of Care

**Requirements/Guidelines:** *There is evidence in the clinical chart that services provided to the member reduce placement disruption and placement in more restrictive levels of care.*

Referrals offered or scheduled appointments shall correspond to the services needed to reduce placement disruptions or placements in a more restrictive level of care. Documentation shall reflect the level of services provided and outcomes related to services delivered to prevent placement disruptions or more restrictive levels of care unless necessary for the health and welfare of the child. Documentation may be available within service plan updates, child/family team notes, or other clinical documentation utilized to demonstrate the effectiveness of services to reduce placement disruptions or placements in more restrictive levels of care. Documentation shall demonstrate efforts to ensure that any out of home placement is in the least restrictive environment for the welfare and clinical needs of the child. Multiple Out of Home placements within the review period should be reviewed and determined if clinically appropriate based on service level intensity.

For out of home and/or unplanned placement changes due to behavioral health symptoms reviewers will include:

- Emergency or unplanned placement changes over 24 hours,
- Shelter care placement,
- Treatment facility placement,
- Runaway episodes,
- Placements for juvenile justice purposes.

Reviewers will exclude:

- Visitation with siblings/relatives,
- Hospitalization (medical treatment, acute psychiatric episodes or diagnoses),
- Respite care,
- Day/summer camps,
- Trial home visits.

#### Scoring:

**Yes:** The clinical chart includes sufficient documentation indicating services provided to the member were effective at reducing placement disruptions and more restrictive levels of care. Documentation indicates that the member did not experience an unplanned placement change or out of home placement due to behavioral health symptoms OR if a member was placed out of home, documentation is present to justify that the level of care is the least restrictive to meet the member's needs.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

**No:** The clinical chart indicates that the member experienced an unplanned placement disruption or out of home placement and documentation does **not** include sufficient evidence that services provided to the member were effective at reducing placement disruptions and more restrictive levels of care. The member is placed out-of-home and documentation does **not** sufficiently demonstrate that the member was placed at the least restrictive level of care to meet the member's needs.

### DCS CHP (DCS CHP-3): Symptom Reduction

**Requirements/Guidelines:** *There is evidence in the clinical chart that services provided to the member reduced symptoms.*

The intention of this element is to determine if services provided to the member reduced symptoms. The reviewer should consider that recovery is not linear and an increase in symptoms during the review period does not necessarily indicate that the child is not in the process of recovering. Symptoms can be expected to ebb and flow throughout the review period, the reviewer should consider overall whether symptoms are improving or if a child is doing well if they are able to maintain stability in their recovery. It can be expected during times of change or transition in the DCS case that some children can experience an increase in symptoms. The reviewer will need to evaluate if clinically appropriate support was provided to minimize symptom escalation during these times. Documentation will be reviewed to determine if services were re-evaluated in preparation for periods of transition and if services were appropriately responsive to any increases in symptoms. Additionally, the review will evaluate if the services were clinically appropriate to overall reduce the child's symptoms.

#### Scoring:

**Yes:** The clinical chart includes sufficient documentation (e.g., service plan goals, referrals and appointments) indicating services provided to the child were adequately meeting needs to promote symptom reduction. Documentation indicates the child is in recovery and stable, the child's symptoms improved, OR clinically appropriate support was provided to minimize symptom escalation caused by external factors unrelated to services.

**No:** The clinical chart does **not** include sufficient documentation (e.g., service plan goals, referrals and/or appointments), indicating services provided to the child were adequately meeting needs to promote symptom reduction. Documentation indicates that the child's symptoms have increased. Clinically appropriate services and supports were not in place or effective in reducing the child's symptoms.

### DCS CHP (DCS CHP-4): Improvement in Educational Progress

**Requirements/Guidelines:** *There is evidence in the clinical chart that services provided to the member improved the member's educational progress.*

The reviewer will evaluate the clinical chart for ongoing assessment of educational needs. If a member has identified educational needs there is a subsequent service plan goal, services, and collaboration with the education environment to support the identified needs. Referrals offered or appointments scheduled shall correspond to the services needed for improvement in educational progress. Chart documentation may reflect that the member is performing well in school with no behavioral concerns. In this instance there are no identified needs, but ongoing assessment is required to ensure an appropriate response should a need arise. In evaluating whether the services provided to the child were adequately effective in improving educational

## Instruction Guide for the Behavioral Health Clinical Chart Audit

progress, the reviewer should consider whether the services of the provider and CFT reflect a reasonable effort in addressing any identified barriers to progress.

Areas to consider include, but are not limited to:

- Assessments stating member's school status and needs,
- Service plans stating member's school related needs, goals or services,
- Coordination with school staff/supports,
- School related updates documented in progress notes or CFT meeting notes.

In instances, of newly identified educational needs during the review period, the reviewer should evaluate the CFT response, by determining if:

- A CFT meeting was scheduled,
- The service plan updated,
- Referrals were made, and
- Services were implemented within the required 21-day timeframe.

### Scoring:

**Yes:** The clinical record includes sufficient documentation (e.g., service plan goals, referrals and appointments) indicating services provided to the child were adequately meeting needs to promote educational progress. Documentation indicates identified educational needs have been addressed OR that the provider has regularly assessed and determined that the child is doing well in school and there are no educational needs.

**No:** The clinical record does **not** include sufficient documentation (e.g., service plan goals, referrals and/or appointments) indicating services provided to the child were adequately meeting needs to promote educational progress. Chart documentation identifies an educational need, but the need has **not** been addressed OR there is **no** documentation within the clinical chart for the evaluation of potential educational needs.

### DCS CHP (DCS CHP-5): Promotion of Natural Childhood Development

**Requirements/Guidelines:** *There is evidence in the clinical chart that services provided to the member promote natural childhood development.*

Clinical chart documentation includes assessment of child development and developmental history. If a provider has determined that a child is experiencing a delay, have appropriate referrals been made when necessary? Specifically, for this population of children it is possible to see regression in development due to transitions and/or trauma, the clinical chart should reflect ongoing evaluation of the member's development and additional services referred to support transitions and/or trauma related symptoms. Documentation may be available within service plan updates, CFT meeting notes or other clinical documentation utilized to demonstrate the effectiveness of services designed to promote childhood development.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

- In instances of newly identified developmental needs during the review period, the reviewer should evaluate the CFT response, by determining if:
  - a. a CFT meeting was scheduled,
  - b. the service plan updated,
  - c. referrals were made, and
  - d. services implemented within the required 21-day timeframe.

### Scoring:

**Yes:** The clinical chart includes sufficient documentation (e.g., service plan goals, referrals, and appointments) indicating services provided to the child were effective in promoting normal and natural childhood development. Documentation indicates identified developmental needs have been effectively addressed OR that the provider has regularly assessed and determined that the child's development is age typical and therefore there are no developmental needs.

**No:** The clinical chart does **not** include sufficient documentation (absence of service plan goals, referrals, and/or appointments) indicating services provided to the child were effective in promoting normal and natural childhood development. No evidence of ongoing evaluation of the member's development OR if a developmental need was identified and the member was **not** referred for appropriate support and/or services.

### DCS CHP (DCS CHP-6): BHP Participation During CFT Practice

**Requirements/Guidelines:** *There is evidence that the BHP participated in and provided oversight of the CFT Practice.*

The intention of this element is to ensure documentation is present in the clinical chart that the BHP participated in and provided oversight of the CFT practice. BHPs may or may not attend all CFT meetings, but they are required to provide oversight of the CFT process. BHPs provide clinical oversight for the member's care by reviewing/signing off on assessments and services plans, offering clinical support and recommendations for treatment, completing the CFT Facilitation Supervision tool, etc.

BHP participation may be documented in CFT attendance records or in BHP signature on assessments and services plan. BHP participation may also be found in staffing notes that reflect the BHP offering clinical support and recommendations to individuals providing services to the member.

### Scoring:

**Yes:** The clinical chart includes sufficient documentation indicating that a qualified behavioral health professional participates in the CFT process. Documentation includes record of BHP attendance in CFT meetings, BHP signature on assessments and service plans, and/or staffing notes that include BHP clinical recommendations

**No:** The clinical chart does **NOT** include sufficient documentation indicating that a qualified behavioral health professional participates in the CFT process. Documentation does **not** include BHP attendance in CFT meetings, BHP signature on assessments and service plans, and/or staffing notes that include BHP clinical recommendations.

# Instruction Guide for the Behavioral Health Clinical Chart Audit

## DCS CHP (DCS CHP-7): CFT Frequency

**Requirements/Guidelines:** *There is evidence in the clinical chart that CFT meetings are conducted at a frequency consistent with the needs of the child.*

The intent of this element is to ensure that the CFT practice model is utilized to drive the development, integration, and unique individualization of service delivery. The level of complexity is determined individually with each child and family and documentation will include the team decisions regarding the frequency of CFT meetings scheduling.

The frequency of CFT meetings is individualized and scheduled in relation to the child and family's situation, preferences, and level of need. Therefore, no frequency of CFT meetings is required to support this individualized approach. The number of system partners involved and invited to participate in CFT practice by the child and family will contribute to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved. **CALOCUS screening tools will be reviewed, and the level of care indicated will be congruent with the level of identified needs of the member. Members with a CALOCUS score of a 4, 5, or 6, identified as high needs, will receive at minimum monthly contact from the assigned case manager. Additionally, meeting frequency needs to be adjusted over time as the member's needs change. If any member of the CFT requests an emergency CFT meeting one will be held within 7 days.**

### Scoring:

- Yes:** The clinical chart includes sufficient documentation indicating that CFT meetings are conducted regularly, and at a frequency consistent with the identified needs of the child. Meetings are held at a frequency that is consistent with documented team decisions regarding the needed frequency and adjustments to the frequency are made in relation to changes in needs.
- No:** The clinical chart does **not** include sufficient documentation indicating that CFT meetings are conducted regularly, and at a frequency consistent with the identified needs of the child. The member has been identified as having high needs and is over 30 days without contact. Any member of the team has requested an emergency CFT, and one was not held within 7 days. CFT meetings are consistently held at a frequency not congruent with the team-determined frequency.

## DCS CHP (DCS CHP-8): DCS Attendance at CFTs Provider Invitation

**Requirements/Guidelines:** *There is evidence in the clinical chart that the provider invited the DCS Specialist or DCS Specialist's supervisor to attend the CFT meetings.*

The intent of this element is to ensure the provider is collaborating with DCS and inviting DCS to the CFT meetings as required.

### Scoring:

- Yes:** The clinical chart includes sufficient documentation indicating that the assigned DCS Specialist, and/or DCS Specialist's supervisor, were invited to attend all CFT meetings in person, by telephone, or electronically. Documentation indicates DCS specialist or DCS Specialist Supervisor is present in CFT meetings, OR if contact notes are present that include an CFT meeting invitation to DCS.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

**No:** The clinical chart does **not** include sufficient documentation indicating that the assigned DCS Specialist, and/or DCS Specialist's supervisor, were invited to attend all CFT meetings in person, by telephone, or electronically. No record of DCS attendance or invitations sent to DCS.

### DCS CHP (DCS CHP-9): DCS Attendance at CFTs

**Requirements/Guidelines:** *There is evidence in the clinical chart that DCS Specialist or DCS Specialist's supervisor attends the CFT meetings in person, by telephone, or electronically.*

The intent of this element is to ensure DCS attendance in CFT meetings. Providers are only responsible for inviting DCS Specialist but not at fault for DCS Specialist nonattendance.

#### Scoring:

**Yes:** The clinical record includes sufficient documentation indicating that the assigned DCS Specialist, or DCS Specialist's supervisor, attended all CFT meetings in person, by telephone, or electronically. Sufficient documentation shall indicate DCS specialist or DCS Specialist Supervisor is present in CFT meetings, OR there shall be documentation to reflect that the DCS specialist or DCS Specialist Supervisor did not attend CFT meeting.

**No:** The clinical record does **not** include sufficient documentation indicating that the assigned DCS Specialist, or DCS Specialist's supervisor, attended or did not attend all CFT meetings in person, by telephone, or electronically.

### DCS CHP (DCS CHP-10): Behavioral Health and Medical History

**Requirements/Guidelines:** *There is evidence in the clinical chart that available, relevant information about the child, including the child's behavioral health and medical history is provided to members of the CFT meeting participants.*

Relevant documentation may include physical or behavioral health historical information that is gathered as part of the initial or ongoing assessment activities, previous CFT meetings or documentation garnered through coordination efforts with DCS, involved community stakeholders or other behavioral health providers. All providers working with the member receive chart documentation at the time of referral and each time updates are made. CFT members receive copies of the service plan and crisis plans each time updates are made. If information about the child or the family/caregiver is shared during CFT meetings, it is important to follow trauma-informed care principles and recognize the potential for re-traumatization of the child (if present) or family members when sharing historical information. It is important to recognize provider limitations as it relates to HIPAA, the reviewer shall consider evidence that the provider made reasonable efforts to obtain necessary releases but was unable to share information without consent.

#### Scoring:

**Yes:** The clinical chart includes sufficient documentation indicating available relevant information about the child, including the child's behavioral health and medical history, was provided to CFT members, as appropriate. There is evidence within the clinical chart that documentation such as assessments, service

## Instruction Guide for the Behavioral Health Clinical Chart Audit

plans, crisis plans, etc. including relevant behavioral health and medical history were provided to CFT members.

- No:** The clinical record does **not** include sufficient documentation indicating available relevant information about the child, including the child's behavioral health and medical history, which was provided to all CFT members. There is **no** evidence in the clinical chart that chart documentation containing the member's behavioral health and medical history was provided to CFT members as appropriate.

### DCS CHP (DCS CHP-11): Integrated Rapid Response Referral for Initial BH Services-7 Days

**Requirements/Guidelines:** *There is evidence in the clinical chart that there is an initial evaluation within seven days of a request for behavioral health services.*

The clinical chart shall include documentation to confirm timeliness requirements are met for the initial behavioral health service following a referral or request for behavioral health services. **Each time there is a referral or request for a behavioral health service, an initial evaluation occurred within 7 days. This evaluation may occur within a CFT meeting.**

#### Scoring:

- Yes:** The clinical chart includes sufficient documentation indicating that an initial evaluation occurred within 7 days of a request or a referral for a behavioral health service. Documentation indicates that a CFT meeting or another appointment occurred within 7 days to evaluate the need of the request for behavioral health services.
- No:** The clinical chart does **not** include sufficient documentation indicating that the initial evaluation occurred within 7 days of the request or referral for a behavioral health service.

### DCS CHP (DCS CHP-12): Service Delivery Following Integrated Rapid Response

**Requirements/Guidelines:** *There is evidence in the clinical chart that services have been provided at least once per month, following an Integrated Rapid Response referral for behavioral health services.*

The clinical chart shall include documentation to confirm chart compliance with the following requirement: the Contractor shall ensure that each child and family is referred for ongoing behavioral health services for a period of at least six months unless services are refused by the guardian, or the child is no longer in DCS custody. A minimum of one monthly documented service is required. If the member's Integrated Rapid Response occurred less than 6 months ago, the reviewer will verify that a service was provided at least once per month for each month since the Integrated Rapid Response unless there is documentation of declination of services by the legal guardian/HCDM, or unless the child is no longer in DCS custody.

In instances when the IRR was not conducted in compliance with the Jacob's Law timeframe, reviewers shall use the 72 hours from DCS out-of-home placement in which an IRR is required and not the timeframe the IRR was done. If the IRR was completed late, the element will be scored from the 72 hours from DCS out-of-home placement in which an IRR is required.

## Instruction Guide for the Behavioral Health Clinical Chart Audit

### Scoring:

- Yes:** The clinical chart includes sufficient documentation of ongoing services that are being provided at a minimum monthly for at least six months OR monthly since the Integrated Rapid Response, if less than 6 months ago.
- No:** The clinical chart does **not** include sufficient documentation of ongoing services that are being provided at a minimum, monthly since the Integrated Rapid Response.

### DCS CHP (DCS CHP-13): Service Planning Following Integrated Rapid Response

**Requirements/Guidelines:** *There is evidence in the clinical chart that members who received an Integrated Rapid Response referral for behavioral health services, had an individual service plan completed in less than 90 days from their initial assessment.*

The clinical chart shall include the member's individual service plan (ISP), which complies with AHCCCS policy and contract requirements for service plan standards completed in less than 90 days from their initial assessment.

In instances when the IRR was not done in compliance with the Jacob's Law timeframe, reviewers shall use the 72 hours from DCS out-of-home placement in which an IRR is required and not the timeframe the IRR was done. If the IRR was completed late, the element will be scored from the 72 hours from DCS out-of-home placement in which an IRR is required.

### Scoring:

- Yes:** The clinical chart includes sufficient documentation indicating that an ISP was completed in less than 90 calendar days from the initial assessment.
- No:** The clinical chart does **not** include sufficient documentation indicating that an ISP was completed in less than 90 calendar days from the initial assessment OR the ISP in clinical record does not meet minimum AHCCCS requirements to be considered current and complete.