# INSTRUCTION GUIDE FOR THE BEHAVIORAL HEALTH CLINICAL CHART AUDIT

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## TABLE OF CONTENTS

## INTRODUCTION

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

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

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

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

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

| Arnold v. Sarn Stipulation |
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| 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 items. A written request to AHCCCS is required for any recommendations for modifications to the instructions or methodology, as identified in Section F, Attachment F3 Contractor Chart of Deliverables for Behavioral Health Clinical Chart Audit Methodology. *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 four sections:**

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

**Section II:** The Service Plan is defined in contract as, "A complete written description of all covered health services and other informal supports, which includes individualized goals, peer and recovery support and family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life." The 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 that are identified within the assessment and related service plan updates. Items included within the general clinical chart may include but are not limited to: (a) progress notes, Child/Family Team (CFT) or Adult Recovery Team (ART) documentation, (c) Transition Age Youth (TAY) activities, (d) CALOCUS or other assessment documents, (e) High Needs Case Manager involvement, 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.

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

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

## ASSESSMENT COMPONENTS REQUIRED ELEMENTS AND GUIDELINES

This section is designed to evaluate items within the most recent version of an assessment completed for a member. The Assessment is designed to address a member's current needs, but also to allow for reassessments as needed (significant events, or changing needs as identified by the member), and as based on required time frames. Reassessments allow for ongoing evaluation as it progresses to create a more comprehensive portrait of a member's needs and strengths. Reassessments done for significant changes or annually as indicated in policy and contract should evaluate progress or lack thereof and adjust treatment accordingly. During reassessment, an assessor shall determine and indicate if there

have been any changes to the required elements since the last assessment and may indicate no change. There are no specific assessment forms required 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 designed to meet the member's treatment needs. Additional assessments, screenings, or evaluations may be found in other sections of the clinical chart (e.g., General Clinical Chart).

Each element shall be audited relative to the requirements within that element. The criterion for each element is either met or not met according to the requirements, guidelines, and scoring criteria. Responses to indicate N/A will not be utilized as an indicator that the element cannot be scored when the assessment does not meet criteria, based on lack of timeliness or 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.

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

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

**Scoring:**

**Yes:** 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 item is to ensure that the assessment was either completed by a behavioral health professional or, if the assessment was conducted by a Behavioral Health Technician (BHT) or Behavioral Health Paraprofessional (BHPP), it has been reviewed and validated by a BHP. If the BHP signature is not present, OR if it is present, but the review and signature was not completed within a 72-hour time frame as required by the Arizona Department of Health Services (ADHS), the auditor may document this to determine if a performance improvement plan, or referral to ADHS is necessary.

**Scoring:**

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

**No:** The assessment was **not** signed by BHP.

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

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

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

**Scoring**:

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

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

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

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

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

**Scoring:**

**Yes:** The assessment 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 item 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 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 item is to verify the assessor documents key elements of the member's social, emotional, and physical skill development. Developmental history should be completed for all members participating in an assessment 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 item is to verify that a member's history of trauma (e.g., sexual abuse, domestic or community violence, neglect, natural disasters, victim of criminal behavior, etc.) is assessed when clinically appropriate. A member's trauma history is taken into consideration to develop a more accurate understanding of their needs, to address presenting concerns, and to reduce re-exposure to traumatizing events when not clinically appropriate. The assessor may use a trauma screening tool (e.g., ACES, PEARLS, other evidence-based trauma screening tool), or include trauma history within the assessment. The assessor may also have documented that exploration of trauma history is not clinically appropriate at time of assessment.

**Scoring:**

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

**Scoring:**

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

**Scoring:**

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

**No:** The member was **not** screened for substance use and/or substance exposure.

### Assessment (A-11): Living Environment

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

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

**Scoring:**

**Yes**: The member was assessed for needs related to living environment/situation.

**No:** The member was **not** assessed for needs related to 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 item is to determine whether the member has access to social supports through interpersonal relationships or social activities that may facilitate a member's ability to achieve goals. Conversely, factors such as isolation and loneliness may negatively impact a member's ability to achieve desired goals. Evidence may include but is not limited to documentation reflecting who a member may use at times when support is needed (e.g., friend, family, clergy, community group). There may be documentation to indicate that the member does not utilize any social supports. This may include the use of a standardized assessment or screening tool, including but not limited to the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE) or Accountable Health Communities' 10-question Health-Related Social Needs Screening Tool (AHC-HRSN).

**Scoring:**

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

**No:** 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 item is to ensure the assessor evaluates whether the member has current needs and goals related to education and vocational training. This may include education from preschool to college; scholarships, post-retirement, transition between schools or school-to-work, paid/nonpaid settings, volunteer activities, or internship opportunities. Depending on identified needs and goals of the member, the assessor may collect additional information related to strengths and barriers associated with engaging in education and vocational training.

**Scoring:**

**Yes:** 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 judgement.

**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 any education or vocational

needs, OR that it was deemed not appropriate at time of assessment, based on clinical judgement.

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

**Scoring:**

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

**Scoring:**

**Yes:** 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.

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

**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 HCDM section is to ensure the assessor has identified the presence of an HCDM to include their involvement in behavioral health services. For adults, this may be an indicator to reflect the necessity of an HCDM due to the limited capacity of the adult. For children, this may be an indicator that

the Arizona Department of Child Safety (DCS) is the legal entity. Legal documentation should be included within the medical record if indicated that such HCDM involvement is in place.

**Scoring:**

**Yes:** 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 screening agency has been notified.*

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

**Scoring:**

**Yes:** The assessor determined the presence of a 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 17 years and 6 months 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 item is to ensure the assessor identified whether a member currently has been or previously was involved with the legal system in any capacity (e.g., legal issues, as a defendant/respondent (probation, arrests, parole, court-ordered treatment) or as a victim/plaintiff (victim, guardian of victim, etc.). Identification of criminal justice involvement is important when assessing risk and identifying service needs. This may include coordination with other involved agencies (Arizona Department of Corrections, Rehabilitation, and Reentry, Arizona Department of Juvenile Corrections, Probation Officer, etc.). Information from the criminal justice system, probation, parole, or other diversion services may provide important external supports that may be used in the initial service planning process.

**Scoring:**

**Yes:** 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. 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) Arizona Court has determined full and permanent legal guardianship for member.

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

**Scoring:**

**Yes**: 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). 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 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. There is no required template for MSE, it includes information gathered throughout the interview and varies based on the member's age. An MSE is commonly found within the Clinical Formulation in which the assessor provides a descriptive picture of the person through summarization of pertinent data for member's medical/ behavioral health history and mental status findings. Other areas of the clinical chart besides the assessment section, may contain evidence of an MSE.

**Scoring:**

**Yes:** There is a Mental Status Exam included within the clinical chart.

**No:** There is **no** Mental Status Exam included within the clinical chart.

### Assessment (A-22): Diagnostic Impression

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

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

**Scoring:**

**Yes:** There is 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. The service plan should follow a strength-based approach and encourage the development of the needs identified and agreed upon within the assessment. The member will determine how they would measure success and what changes are personally most important and relevant. Attention should be paid to how the member/family interprets their own culture, religion, family practices and/or adherence to specific beliefs and/or traditions. Service plan development shall occur based on the Nine

Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems and the 12 Guiding Principles for Children.

In collaboration with the member, the service plan should establish the member's desired outcomes anytime throughout the course of treatment. During subsequent reviews, the service plan should 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 should be updated in conjunction with the most recent assessment to incorporate additional updates to ensure 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.

### 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. Living environment influences the member's quality of life and ability to achieve their desired outcome may influence their ability to implement their service plan and who might be available for member support. During the service planning process, the member may decline to include a goal in the service plan regarding living environment. Efforts should be documented related to the assessor's attempts to engage the member in addressing the living environment. If securing a safe and appropriate living environment was identified as a need, the assessor should include this as a priority for service planning discussion.

**Scoring:**

**Yes:** 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).*

**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.

**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 should provide a description of how the member would like their life, family, and environment to be once services are no longer needed.

**Scoring:**

**Yes:** 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.

### 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 should 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 supports may include family members, friends, faith-based community supports or other informal services that the member may choose to utilize to achieve desires and goals as identified within the service plan or CFT/ART process.

**Scoring:**

**Yes**: 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 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 item as yes, the auditor must confirm that the provider's offering of peer/family support, is accompanied by documentation that the member/family was offered the choice of providers for this service (e.g., through health home, outpatient behavioral health clinic, Community Service Organizations [CSA]s, **and** peer and family run organizations).

**Scoring:**

**Yes:** 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).*

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

**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.

**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. **Adding the member to a waitlist or sending the referral, does not qualify as implementation.**

### General Clinical Chart (GCC-6): CALOCUS Assessment

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

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

**Scoring:**

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

**Scoring:**

**Yes:** There is 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). 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. If there is documentation within the chart to indicate that member indicated no crisis or safety concern, or that they were not recently discharged from an inpatient setting, this documentation would qualify as evidence that the crisis safety concerns have been addressed.

**Scoring:**

**Yes**: Identified crisis and/or safety concerns were addressed in a crisis/safety plan in the clinical chart.

**No:** Identified crisis and/or safety concerns were **not** addressed in a crisis/safety plan in the clinical chart.

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

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

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

**Scoring:**

**Yes:** 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.

**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, this would be given a no in the scoring for the member.

### 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.*

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

**Scoring:**

**Yes:** 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. If the member already has an SED designation, that may be included under the N/A response.

**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.

**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 Determination element is to ensure individuals receive a prompt and accurate referral to the Determining Entity, if a provider determines the need exists and/or if the member requests an SMI Eligibility Determination. If documentation indicates that a member or health care decision maker requests an SMI Eligibility Determination or if there is documentation regarding the need for an assessment, there must be evidence within the clinical chart that an SMI Eligibility Determination request has been submitted to the SMI Determining Entity. Members or Health Care Decision Makers can always decline an SMI Eligibility Determination and therefore credit will be given for documenting that a member or 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 Determination was offered. If the member already has an SMI designation, that may be included under the N/A response.

**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.

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

**Scoring:**

**Yes:** The member with an SMI designation was assessed for meeting criteria for Special Assistance.

**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 should 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

should 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 should reflect the culture and identity of the member or child and family or HCDM (e.g., race, and ethnic background, national origin, color, sex, sexual orientation, gender identity or expression, age marital status, political belief, religion, immigration status, and mental or physical ability). Cultural preferences of the member are honored in the service plan, and may also be addressed within the CFT or ART. The member's preferences should be identified to further customize treatment to his/her unique cultures, faith, traditions, and priorities. Preferences about behavioral health services relating to spiritual beliefs or any other factors (e.g., provider gender preference, utilization of alternative medicine or traditional healer, sexual orientation) should be documented in the clinical chart. Merely listing a member's strengths outside the context of a cultural description does not reflect cultural preferences. The ethnic, racial, familial, regional, or spiritual culture in which individuals reside 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.

### 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.