

CalAIM ASSESSMENT

Completed By:

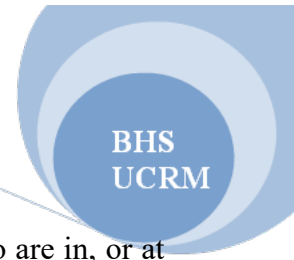
1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor **
4. Physician (MD or DO)
5. Nurse Practitioner/Physician Assistant
6. Registered Nurse
7. Registered Psychological Associate
8. Clinical Trainee

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| <ol style="list-style-type: none">8. Licensed Psychiatric Technician/Vocational Nurse*9. Registered PsyD, MHRS* |
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Compliance Requirements:

- Initial CalAIM Assessment shall be completed within a clinically appropriate timeframe.
- Updated CalAIM Assessment – Programs use their clinical expertise to complete subsequent CalAIM Assessments as expeditiously as possible, in accordance with each member’s clinical needs and generally accepted standards of practice. Assessments shall be updated as clinically appropriate, such as when a member’s condition changes. *Some SMH services, such as residential levels of care, STRTPs, etc are subject to licensure or certification requirements that include additional standards for member assessments and those standards remain in effect. See [BHIN 23-068, Enclosure 1b](#).
- All Domain fields must be completed as per *BHIN 23-068*. The seven uniform assessment domains are identified below w/ specific elements that should be included in each:
 - Domain 1: Presenting Problem(s), Current Mental Status, History of Presenting Problem(s), Beneficiary-Identified Impairment(s)
 - Domain 2: Trauma
 - Domain 3: Behavioral Health History, Comorbidity
 - Domain 4: Medical History, Current Medications, Comorbidity with Behavioral Health
 - Domain 5: Social and Life Circumstances, Culture/Religion/Spirituality
 - Domain 6: Strengths, Risk Behaviors, and Safety Factors
 - Domain 7: Clinical Summary and Recommendations, Diagnostic Impression, Medical Necessity Determination/Level of Care/Access Criteria
- Access Criteria Medical Necessity Criteria shall be substantiated as per [BHIN 21-073](#).
- ICD-10 Mental Health Diagnosis shall be substantiated.
- Providers who serve children/youth shall ensure that all children/youth are assessed for eligibility to receive ICC or IHBS services during the assessment process. Membership in the Katie A class or subclass is not a requirement for receiving medically necessary ICC, IHBS or TFC.
 - BHP’s are obligated to provide ICC/IHBS services to all children and youth under the age of 21 who are eligible for full scope Medi-Cal and who meet medical necessity

for these services. The determination of medical necessity must be in accord with the guidance provided within the [Medi-Cal Manual for ICC, IHBS and TFC Services for Medi-Cal Beneficiaries](#) which states that BHPs must make individualized determinations of each youth's need for ICC/IHBS based on the youth's strengths and needs.



- These services are appropriate for children and youth with more intensive needs who are in, or at risk of, placement in residential or hospital settings, but could be effectively served in the home and community.
- These youth should be entered into the appropriate Special Populations category in SmartCare which will link the appropriate required modifier (HK) to the service for billing purposes as well as allowing for tracking of these youth/services.
 - Special populations “ICC/IHBS” is used for any youth receiving ICC/IHBS services.
 - Special populations “Katie A ICC/IHBS” is used for any youth that would have been considered “subclass” under previous PWB criteria. Determination of class or subclass is no longer required, however the State recommends that counties continue to track these youth.

Documentation Standards:

- CalAIM Assessments shall be updated in real time to capture current clinical information.
- Co-signatures, when required, must be completed to be considered a completed assessment.
- A MHRS/LVN/LPT/Registered PsyD/Ph.D may only complete an assessment for the sections that are within their scope.
 - The CalAIM Assessment cannot be completed by a non-LPHA/LMHP staff as it is out of scope. A MHRS/LVN/LPT/Registered PsyD/Ph.D may gather information that supports assessment domains within their scope of practice and enter into their progress note and claim for the Assessment by Non-LPHA procedure.
 - This progress note requires an approved review and co-signature by a licensed/registered/waivered staff. An LPHA/LMHP can then review the assessment information in the progress note and copy this information into the relevant domains of the CalAIM Assessment and complete the assessment with the client claiming for their direct client time. LPHA/LMHP indicates “Information obtained by provider Name, Credential” for any information that was copied over to assessment from the non-LPHA/LMHP progress note.

Domain 1- Presenting Problems/Needs:

- Include precipitating factors that led to deterioration/behaviors.
- Describe events in sequence leading to present visit.
- Describe beneficiary-identified problem(s), as well as history and impact of presenting problem(s), on beneficiary.

- Include impairment(s) identified by the beneficiary including distress, disability, or dysfunction in an important area of life.
- Include current mental status which describes the beneficiaries mental state at the time of assessment.
- Describe juvenile justice or foster care involvement and experience of trauma.
- Include summary of beneficiary's request for services including client's most recent baseline.

Domain 2- Trauma: Describe any current or past exposure to trauma.

Domain 3- Behavioral Health History/Co-Occurring Substance Use: Previous history of symptoms and/or mental health treatment.

- Describe in chronological order - where, when, and length of time of acute and chronic conditions.
- Include dates and providers related to any previous community-based treatment, including providers, therapeutic modality (e.g., medications, therapy, rehabilitative interventions, etc.) and response to interventions.
- Include prior psychiatric inpatient admissions and/or crisis-based admissions.
- Document exposure/substance use including past and present use; previous community-based treatment including providers, therapeutic modality (e.g. medication-assisted treatment, rehabilitative interventions) and response to interventions; intoxication/detox/ withdrawal management-based admissions.
- Address if client has a co-occurring disorder.
- Describe how the client's substance use impacts their current life functioning and behavioral health symptoms.

Domain 4- Medical History/Current Medications/Co-occurring Conditions:

- Describe any relevant current or past physical health conditions, history of medical treatments and response(s) to treatment, as relevant include: significant prenatal and perinatal events, and/or significant developmental history.
- Address if the client has a Primary Care Physician and if not if they were referred to one.
- Document current medications and history of medications.

Domain 5 Social and Life Circumstances/Culture/Religion/Spirituality:

- Describe any social concerns and how they are related to or impact their behavioral health and functioning.
- Describe current living situation and list all individuals living in the home with the client.

- Provide relevant family history and current family information – include domestic violence, substance use, neglect/abuse, family involvement and structures and level of support.
- Considerations could include language of client/family, primary language spoken at home, religious, spiritual beliefs, family structures, customs, moral/legal systems, life-style changes, socio-economic background, ethnicity, race – including tribal, BIPOC affiliations, LGBTQ affiliations, immigration history/experience, age, and subculture (homelessness, gang affiliations, substance use, foster care, military background), exposure to trauma, violence, abuse and neglect, experience with racism, discrimination, and social exclusion.
 - For Child/Youth, document juvenile justice involvement or involvement in the child welfare system.
 - Describe unique cultural and linguistic needs and strengths that may impact treatment.
 - Cultural information includes an understanding of how client's mental health is impacted.

Domain 6 -Strengths/Risk Behaviors/Protective Factors:

- Describe client strengths related to their mental/behavioral health needs and functional impairments. Describe how client strengths will support treatment goals.
- Describe family strengths as they may relate to and support beneficiary's mental/behavioral health needs and functional impairments.
- Describe history or current risk for self-injury, suicidal ideation or attempts and any risk of violence or past violence.
- Describe the protective factors. Document any strengths in achieving goals, personal motivation/drive/interest, resilience and coping skills, strong religious, cultural, or inherent values against harming self/others, strong social support system and availability of resources and opportunities, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others or activities (routines/social hobbies) or family/community/professional systems.

Domain 7- Clinical Summary and Recommendations/Diagnostic Impression/Medical Necessity Determination/LOC/Access Criteria:

- Summary of clinical and diagnostic impressions, capture diagnostic uncertainty such as provisional or unspecified diagnosis, etiology, clinical complexity, impairments, level of care, medical necessity determination, and service recommendations for treatment episode. (It is out of scope for a MHRS/LVN/LPT to complete the assessment for diagnostic impressions. The assessment for diagnostic impressions must be completed by a licensed/registered/waivered clinician.
- The assessment may be completed in one or more sessions.
- Paper forms are only to be completed when the EHR is not accessible, and the expectation is that the information is scanned into EHR as promptly as possible.