County of Sacramento **Department of Health and Human Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-10-26**
	Effective Date	**07-01-2014**
	Revision Date	**07-01-2022**
Title: **Core Assessment (Mental Health)**	Functional Area: **Chart Review - Non-Hospital Services**	
Approved By: (Signature on File) **Signed version available upon request** **Alexandra Rechs, LMFT** Program Manager, Quality Management		

BACKGROUND/CONTEXT:

The Core Assessment is the primary assessment used by Sacramento County Division of Behavioral Health Services and the Mental Health Plan (MHP) providers in the Avatar Clinician Workstation (CWS) electronic health record. Providers with their own Electronic Health Record (EHR) utilize an equivalent vetted Assessment Document which contains all of the same required elements. The Core Assessment shall include the provider's determination of medical necessity and recommendation for services. The Assessment details important information and history related to the client's reasons for service, psychosocial history, problem and risk areas, and other key areas of client functioning and history. Under CalAIM, providers are required to use Department of Health Care Services (DHCS) identified uniform assessment domains and for beneficiaries under age 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool is required to be utilized and should inform the assessment. (See QM P&P 01-07 Determination for Medical Necessity and Access to Specialty Mental Health Services and DHCS Behavioral Health Information Notice (BHIN) 17-052 Performance Outcome System Functional Assessment Tools).

PURPOSE:

The purpose of the Core Assessment, capturing the CalAIM Seven Domains, is to understand the person's needs and circumstances, in order to recommend the best care possible and to help the person recover. The assessment must be completed under the guidance of an LPHA. The assessment evaluates the person's mental health and well-being and explores the current state of the person's mental, emotional, and behavioral health and their ability to thrive in their community. An assessment may require more than one session to complete. It may also require the practitioner to obtain information from other relevant sources, referred to as "collateral information", such as previous health records or information from the person's support system. This is done in order to gather a cohesive understanding of the person's care needs. The Core Assessment is completed in conjunction with the Mental Status Exam (MSE). Physical Health history information is gathered in a separate Health Questionnaire (HQ) form. Other assessment forms may be required as applicable to program requirements.

The purpose of this policy is to establish guidelines, requirements, and timelines for completion of the Core Assessment. The policy provides clinical guidelines for completion of the Core Assessment as well as how the current Avatar Core Assessment can be used to meet the requirements of the Cal Aim 7 Domains. It is not a substitute for technical training in use of the Avatar CWS system. This policy is applicable to providers with their own EHR Assessment Documents as well.

DEFINITIONS:

Assessment Start Date: First billed assessment that the MHP provided to the client. The assessment shall be completed by the assigned Provider. The first Medi-Cal billable service initiates the timeline for the Clinical Bundle.

Clinical Bundle: The required documentation to be completed by the assigned provider including Assessment Documents and if applicable, Client Plan. Refer to QM Documentation Training: CWS Documentation Bundles and your contract for the specific required documentation.

Assessment 7 Domains: The assessment contains universally-required domains that should not vary from MHP to MHP or Agency to Agency. Below is information on the standardized domains comprising the assessment for understanding the person's care needs. While each of the domains are required and must be addressed, information may overlap across domains. When conducting an assessment, it is important to keep in mind the flow of information and avoid duplication to ensure a clear and ideally chronological account of the person's current and historical need is accurately documented. Include the perspective of the person being assessed and, whenever possible, use their quotes within the document.

DETAILS:

It is the policy of Sacramento County MHP that a Core Assessment be completed for all clients.

1. Core Assessment: The time period for providers to complete an initial assessment and subsequent assessments for SMHS is up to clinical discretion; however, providers shall complete assessments within a reasonable time and in accordance with generally accepted standards of practice. Sacramento County considers it best practice to complete the assessment within 90 days, unless there is documentation of any issues (i.e., acuity, homelessness, difficulty with engagement) that prove to be a barrier to completion. Assessments not completed during these timelines will not result in recoupments.

2. Updates to the Core Assessment can be documented in a progress note and include any items of clinical significance. The Assessment billing code should be used and the Problem List updated for monitoring and tracking purposes.

3. Staff qualified to complete the Core Assessment are identified in the Avatar CWS Documentation Matrix. If a staff that is not licensed or licensed waived is contributing to the assessment this shall be done in collaboration with, direction by, and with oversight of the LPHA who is responsible for the completion and co-signing of that Core Assessment. Staff who are not licensed or licensed waived may contribute to the assessment by gathering the following information: the beneficiary's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals. (See Staff Registration P&P and Billing Privilege Matrix).

4. Core Assessments are not considered complete unless they are signed; co-signed, if required, and finalized. (See Billing Privilege Matrix).

5. Clients transferred within the Sacramento County MHP require a new Core Assessment within 60 days, or as clinically appropriate, from the date of transfer. Transferring providers should coordinate with the new provider to provide successful linkage, coordination of care, and transfer of assessment information.

6. A Core Assessment Report format must be used when a printed "hardcopy" form or PDF "softcopy" of the document is needed from Avatar. "Screen shots" of CWS data entry screens are not acceptable and may include restricted client information that cannot be legally shared or viewed. Providers with their own EHR should ensure that printed reports do not contain restricted client information.

7. Items identified in the current Core Assessment that crosswalk to the Seven Domains listed in the DHCS BHIN 22-019 are required and must be completed. Items titled in red in Avatar are required by the Avatar CWS system for completion and submission of the form. All applicable items must be completed as part of a complete assessment. Providers using their own EHR must include the information required in the Seven Domains in their assessment template.

8. A diagnosis from the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) with a corresponding Department of Health Care Services (DHCS) approved ICD-10 code must be documented in the diagnosis section. This diagnosis must be consistent with the presenting problems and mental status exam.

PROCEDURE:

The Core Assessment may include the following information based on the CalAIM Seven Domains (See CalMHSA_MHP_LPHA_Documentation Guide [pages 12-15] for domain categories, key elements, and guidance on information to consider under each domain):

For Providers using Avatar, see Attachment 3 – Avatar 7 Domains Crosswalk for current location of required elements.

Domain 1:

Requirements:	Description:
• Presenting Problem(s) • Current Mental Status • History of Presenting Problem(s) • Beneficiary-Identified Impairment(s)	Chief complaint • Beneficiary-identified problem(s), history of the presenting problem(s), impact of problem(s) on beneficiary • Beneficiary's mental state at the time of the assessment • Impairment identified by the beneficiary including distress, disability, or dysfunction in an important area of life function

Domain 2:

Requirements:	Description:
• Trauma	History of trauma or exposure to trauma: • Any psychological, emotional response to an event that is deeply distressing or disturbing • A measure of trauma indicating elevated risk for development of a mental health condition • Experience with homelessness, juvenile justice involvement, or involvement in the child welfare system

Domain 3:

Requirements:	Description:
• Behavioral Health History • Comorbidity	Mental Health History: • Acute and chronic conditions

	• Previous community-based treatment, including providers, therapeutic modality (e.g., medications, therapy, rehabilitative interventions, etc.) and response to interventions • Inpatient admissions • Crisis-based admissions Substance Use History: • Exposure/substance use, including past and present use • Previous community-based treatment, including providers, therapeutic modality (e.g., medication-assisted treatment, rehabilitative interventions, etc.) and response to interventions • Inpatient psychiatric admissions • Intoxication/detox/withdrawal management-based admissions

Domain 4:

Requirements:	Description:
• Medical History • Current Medications • Comorbidity with Behavioral Health	Medical History: • Relevant current or past physical health conditions • Prenatal and perinatal events, and relevant or significant developmental history • History of medications, medical treatments, and responses • Allergies to medications

Domain 5:

Requirements:	Description:
• Social and Life Circumstances • Culture/Religion/Spirituality	• Psychosocial factors: • Living situation, daily activities, social support, and cultural and linguistic factors • Legal or justice-involved history • Family history and current family involvement • Military history • Tribal affiliation • LGBTQ • BIPOC

Domain 6:

Requirements:	Description:
• Strengths • Risk Behaviors • Safety Factors	Strengths, risk behaviors and safety factors: • Strengths in achieving goals, including personal motivation, drive, and interest • Resilience and coping skills • Protective Factors, including the availability of resources, opportunities, and supports (including support persons), interpersonal relationships, systems (family/community/ professional), activities (routines/ social hobbies/ etc.)

	• Situations and triggers that may induce risky behaviors • Suicidal/homicidal ideation • Safety planning, including an individualized plan that can be self-initiated or initiated by a trusted person (e.g. sponsor)*

*__The Core Risk Assessment should inform the use of the Safety Plan__

The below sections in Avatar are optional and will be discussed in County Documentation Training:

- Pertinent Intergenerational Issues.
- Stage of Change Data
- Youth Specific Information

Domain 7:

Requirements:	Description:
• Clinical Summary and Recommendations • Diagnostic Impression • Medical Necessity Determination • Level of Care/Access Criteria	Clinical impression, including etiology, clinical complexity, and impairments: • Predisposing, precipitating, perpetuating and protective factors • Diagnosis/ICD-code consistent with presenting problems, history, mental status exam and/or other clinical data, including any current medical diagnosis. Capture diagnostic uncertainty (provisional or unspecified) • Service recommendations for the treatment episode

Providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

- In cases where services are provided due to a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS approved ICD-10 diagnosis code list 1, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services.

Avatar Specific Guidance:

Collateral Assessments: Select from completed Adult or Child MSE and Adult or Child HQ to link to Core Assessment in Avatar.

Note: An MSE must be selected and linked to "Finalize" the Core Assessment in Avatar.

Reasons for Services: "Please enter the Issues that have been established during the Core and Collateral Assessments." Up to five Reasons for Services can be entered and will be available to populate in the Client Plan for this Client.

Select all applicable areas for "Treatment is being provided to address or prevent significant deterioration in an important area of life functioning."

Draft and Finalize: Select supervisor in "Send to" field if supervisor approval is required. Include comments for supervisor in "Send to Outgoing Comments" field if applicable. Select "Workflow Control" as Draft, Final, or Pending Approval.

Note: "Submit" must be clicked after selecting Workflow Control to save in draft, submit to supervisor for approval, or finalize Core Assessment.

REFERENCE(S)/ATTACHMENTS:

- Attachment 1 - Avatar CWS Documentation Matrix
- Attachment 2 - Staff Billing Privileges Matrix
- Attachment 3 - Avatar-7 Domains Crosswalk
- Mental Health Plan Contract
- California Code of Federal Regulations, Title 9, Chapter 11, Section § 1810.204. Assessment
- MHSUDS IN# 17-040
- BHIN 22-019
- CalMHSA MHP-LPHA Documentation Manual 05-2022

RELATED POLICIES:

- QM 10-27 Client Plan
- QM 01-07 Determination for Medical Necessity & Access To Specialty Mental Health Services
- QM 10-02 Health Questionnaire
- QM 10-29 Mental Status Exam

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	X	Children's Contract Providers
X	Mental Health Treatment Center	X	Substance Use Prevention and Treatment
X	Adult Contract Providers	X	Specific grant/specialty resource

CONTACT INFORMATION:

- Quality Management Information
  QMInformation@saccounty.gov

Crosswalk CalAIM Standardized Assessment to Avatar Core Assessment

	Cal Aim Domains	Avatar Core Assessment
Domain 1:	Presenting Problem/Chief Complaint Current Mental Status History of Presenting Problem(s) Beneficiary-Identified Impairment(s)	Current Presenting Reason MSE captured in collateral form within clinical bundle Behavioral Health History ("own words")
Domain 2:	Trauma Trauma Exposures, Trauma Reactions, Trauma Screening Systems Involvement	Trauma History: Use comments to capture required information
Domain 3:	Mental Health History Substance Use/Abuse Previous Treatment Services	Substance Use Issues Impacting Client Prior Psychiatric Hospitalizations History of Psychiatric Hospitalizations/Partial/residential tx Outpatient treatment History Family Mental Health History
Domain 4:	Medical History-Physical Health conditions Current Medications Comorbidity with Behavioral Health Developmental History (for individuals 21 and under)	Health Questionnaire-separate form in clinical bundle Select adult or child HQ as appropriate Add current and past medications in comments, OTC and non-psychiatric medications
Domain 5:	Social and Life Circumstances Family History and Involvement Culture/Religion/Spirituality	Psychosocial History Developmental Issues/Childhood Events/Family Hx Immigration/Acculturation Social Activities/Relationships/Interests Education and Employment Sexual History (restricted) Past/Present Criminal Justice History Cultural/Spiritual Background Gender/Sexual Orientation (restricted)
Domain 6:	Strengths and Protective Factors Risk Factors and Behaviors	Risk Assessment Support/Strengths Use comments section to identify protective factors
Domain 7:	Clinical Summary and Recommendations Diagnostic Impression • Medical Necessity Determination/Level of Care/Access Criteria	Clinical Formulation LOCUS-separate form as required (FSP) Collateral assessments to link HQ and MSE

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