YOLO COUNTY Health & Human Services Agency

Avatar CalAIM Standardized Mental Health Assessment

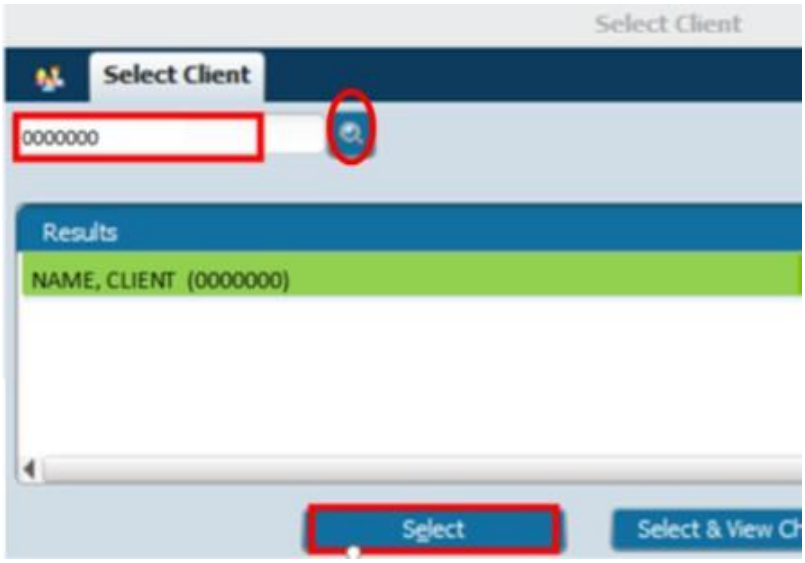
Desk Reference

The purpose of this desk reference is to provide users information on accessing and entering information for the "Standardized Mental Health Assessment" in alignment with documentation standards.

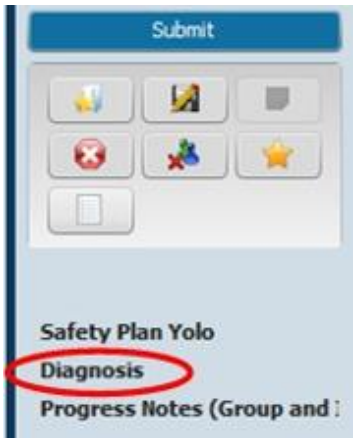
- **Uses:** The Standardized Mental Health Assessment gathers information about the member's mental health needs and other areas of life experience and functioning. The assessment helps determine appropriate services and referrals to other appropriate agencies & resources.
- Outpatient initial assessment and reassessment due dates are not based on strict timelines, but rather on clinical discretion (i.e., assessments must be completed within a reasonable time and in accordance with generally accepted standards of practice: DHCS BHIN 23-068). Please speak to your supervisor if you need guidance on how long an assessment will usually take to complete.
- **Navigation Tips:** The Standardized Mental Health Assessment is composed of nine "pages" that are listed on the left of the form when it is open. You will access different pages of the assessment from that menu. You may move from one page to another to add or change information but be aware that all fields that have red text are fields that must have information entered in them.

Steps to Access Form:

- **Menu path**: Avatar CWS/Assessments/Yolo County Assessments (or you can enter "Standardized" under Search Forms and select the assessment)
  - After the "Standardized Mental Health Assessment" form has been selected and launched, in the Select Client screen, enter the member ID, click the Search button, and select the correct entry:



  - Select the correct episode, click OK. In the Select Episode field, click the drop-down arrow to display the client's episode history. If the client has multiple episodes the episode pre-display shows.



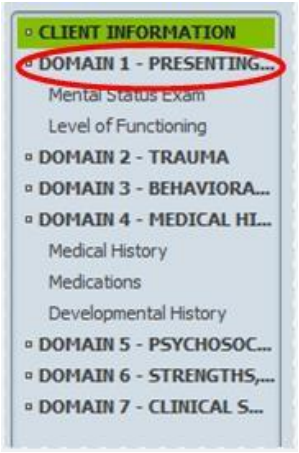
- Once the client and episode have been selected, associated Diagnosis information will display on the top of the screen. For ongoing clients, review the information for accuracy and update the Diagnosis Form with current information when applicable. For new clients, this will likely be blank. Enter a diagnosis on the Diagnosis Form in this scenario (see Diagnosis Form and Problem List Desk Guide).

- If diagnoses entries or updates need to be made to the Diagnosis Form, that can be accessed through a link on the bottom left side of the Standardized Mental Health Assessment Form. Please refer to the desk reference on the Diagnosis Form/Problem List for instructions on adding and editing Diagnosis Forms.

Steps to Complete the Form

The assessment includes seven different required domains. Each domain addresses an area of information to be gathered and used in clinical formulation, determination of appropriate services and support for the member, and for treatment planning throughout the member's treatment services.

While it is important to gather complete **i**nformation from the member, if a member is unable or unwilling to answer some parts of the assessment, please indicate in the information input area if the member declines or is unable to provide that information.

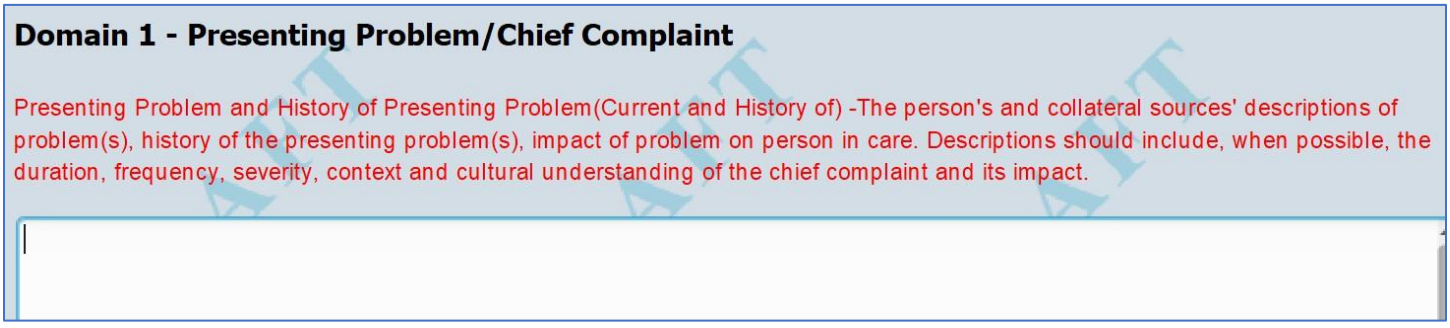


Client Information

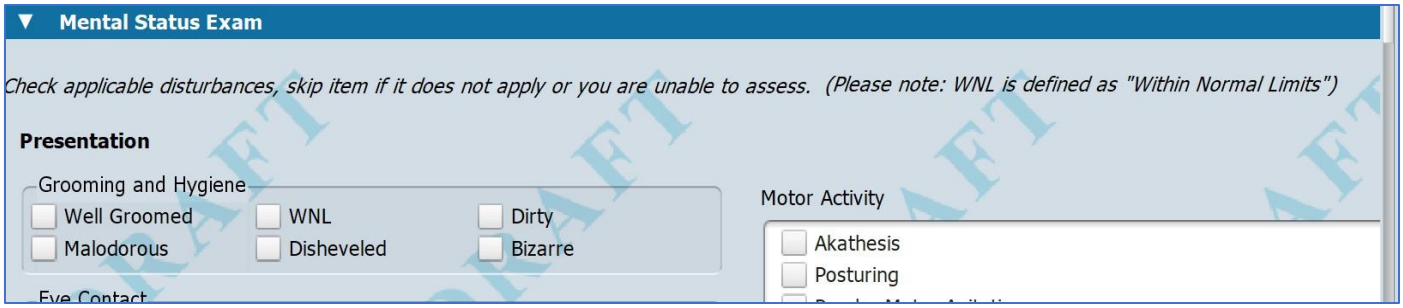
- The initial section of the Standardized Mental Health Assessment lists general information about the assessment (such as the date it was started, if it's an initial or reassessment, etc.) and demographic information about the client (like age group, preferred language, etc.)

Domain 1: Presenting Problem(s), Current Mental Status, History of Presenting Problem(s), Member-Identified Impairment(s). Once the initial demographic section has been completed, click on "Domain 1: Presenting Problem" on the left-hand side of the screen to begin entering information about the presenting problem.

- The Presenting Problem/Chief Complaint section is a narrative. There are prompts listed at the top of the text box to guide the user through the type of clinical information that is typically included. One goal of CalAIM documentation reform is streamlining of documentation so it's important to note that once information has been mentioned, it does not need to be repeated in other areas of the assessment. <u>Information documented in this section does not need to be copied/pasted or repeated in subsequent sections.</u>



- The Mental Status Exam (MSE) and Level of Functioning sections are part of the first domain of the standardized assessment. It is comprised of check boxes that the user selects to record the member's mental status and functioning. Only select items that apply to the member at the time of the assessment; this section is not meant to capture historical information. If there is no need to check anything in a section, leave it blank. Users may select more than one box per section – select as many as applicable. You can navigate this section by using the scroll bar feature on the right side of the screen.



Domain 2: Trauma

- Use the menu at the left to navigate to Domain 2.
- This section contains multiple trauma-related prompts and spaces for the user to type narratives according to available information.. Address the narrative prompts and use the scroll bar on the right of the screen to work through the section.

Domain 3: Behavioral Health History

- Once the user has completed Domain 2, return to the top left of the screen and select Domain 3: Behavioral Health History.

- This section also has several prompts with space for the user to input narrative information.. Address the narrative prompts and use the scroll bar on the right of the screen to work through the section.

Domain 4: Medical History and Medication

- Once the user has completed Domain 3, return to the top left of the screen and select Domain 4: Medical History and Medication.

- This section is a combination of prompts with narrative text and check boxes. The user will assess for physical and medical conditions, disabilities, illnesses, etc. Note that it is not necessary to have proof of physical/medical condition diagnoses; the user will record information provided by the member and appropriate support persons or parents/guardians, as applicable.

- For members under 21 years of age, the Developmental History section will be completed. If that is not applicable, leave it blank.

Domain 5: Psychosocial Factors

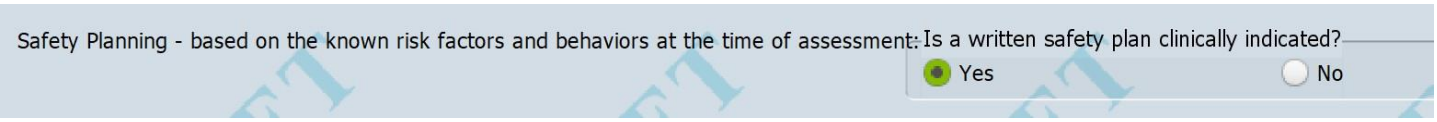
- Once the user has worked through Domain 4, return to the top left of the screen to select Domain 5: Psychosocial Factors.

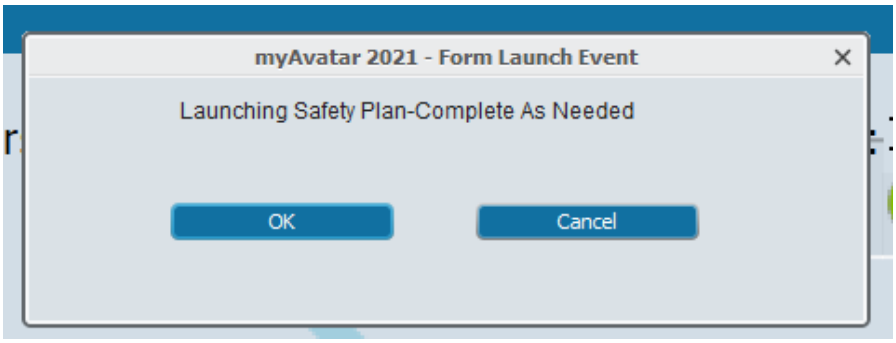
- This section contains several prompts with areas to enter narrative information. Read the prompts carefully to ensure you are assessing for relevant information in these sections.

Domain 6: Strengths, Risk and Protective Factors

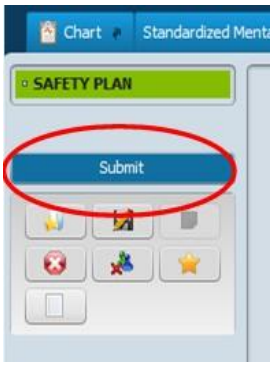
- Once the user has worked through Domain 5, return to the top left of the screen to select Domain 6: Strengths, Risk and Protective Factors.

- This section has both narrative and check box functionality. For checkboxes, check only those currently known at the time of assessment and leave unknown items blank. It's important to conduct a thorough risk assessment. If the assessor determines that, based on the risk assessment, a safety plan is indicated, there is a question to indicate that conclusion, which launches a separate Safety Plan form:





1. Select "OK" to launch the safety plan
   Discuss with the client responses to each of the prompts. This helps to write a very client-specific safety plan, identifying their warning signs for increased risk, what internal coping strategies they may use, what people and social situations may be helpful, what professional resources they can turn to, etc. Once completed, select "Final", then select "Submit" near the top left of the form.



2. This will then display the Safety Plan Report which should be printed and given to the client for their reference/use. If the assessor identifies significant risk and believes the member may not be able to maintain their and others' safety or is gravely disabled, seek appropriate supervisory assistance.
   - (**Note:** This Safety Plan can be accessed as a stand-alone form without the need to go through the Standardized Mental Health Assessment Form to access it. Please use it as clinically indicated to support clients in addressing potentially harmful circumstances. Select it as you would other forms, through the "Search Forms" function.)

Domain 7: Clinical Summary, Treatment Recommendations, Level of Care Determination

- Once the user has worked through Domain 6 (and completed a safety plan if indicated), return to the top left of the screen to select Domain 7: Clinical Summary, Treatment Recommendations, Level of Care Determination.
- This section is composed of several text prompts with space for the user's narrative. Again, if information has been documented elsewhere in the assessment it should not be repeated here.
- In the Clinical Impression section, the user documents their clinical analysis of the facts and information gathered during the assessment. From this, they formulate a diagnostic impression and make treatment recommendations. Remember that if the diagnosis needs to be updated based on assessment findings, a link to the diagnosis entry form may be found on the left under "Diagnosis." Once this domain has been completed, click on the "Submit" button on the upper left-hand side of the screen: Note: If the user has left required fields blank, a pop-up window will appear indicating that the assessment may not be submitted due to fields that are missing. The pop-up will list the items that must be completed before submission.