CLINICAL DOCUMENTATION GUIDE

2022

California Mental Health Services Authority (CalMHSA)

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INTRODUCTION TO THIS MANUAL

The California Medi-Cal system is undergoing a significant transformation to reform the program in service of improving the quality of life and health outcomes of Medi-Cal members. This person-centered approach, operationalized by the Department of Health Care Services (DHCS), through its California Advancing and Innovating Medi-Cal (CalAIM) initiative, streamlines processes and documentation in order to better address the needs of persons in care while improving access to and coordination among the delivery systems responsible for providing care. DHCS aims to provide Californians with access to equitable, integrated, cost-effective and high-quality health care.

The intent of this documentation manual is to support the implementation of DHCS guidance concerning care coordination efforts between the Mental Health Plan (MHP) and Managed Care Plan (MCP) services delivery systems (e.g., screening, transition of care and service referrals), and the essential documentation requirements for specialty mental health services and claims reimbursement. Specifically, this manual provides guidance to certified Medi-Cal Peer Support Specialists in an MHP setting that claims outpatient Medi-Cal services. This documentation manual will cover many relevant topics and concepts that support your work with children, youth, adults, and families. The audience for this manual includes both those peer support staff who are new to documentation of services, as well as those practitioners who have experience with pre-CalAIM documentation standards. Aligned with CalAIM, readers will note the use of person-centered language, the focus on clinical treatment and a trauma-informed lens as key elements of the manual. For example, individuals receiving treatment will be referred to as "people" or "people in care", rather than "clients", "patients", or "beneficiaries".

CERTIFIED PEER SUPPORT SPECIALIST ROLE

Peer Work

The peer recovery support movement emphasizes services that are delivered and designed by people who have experienced both substance use and recovery. Peers elevate the voice of recovery through serving as living testaments to recovery and helping others along their recovery journey. Peer Workers provide a range of activities including advocacy, coaching, modeling, mentoring, self-assessment and supporting individuals in building healthy relationships and natural supports to remain active participants in their communities.

While there are many roles for peers, the focus in this manual is on the role certified Medi-Cal Peer Support Specialists. Before moving on to the specific role of certified Medi-Cal Peer Support Specialist, we want to acknowledge the years of ongoing contribution by Peer workers in behavioral health programs. Peer workers continue to have an important role in the delivery of behavioral health services, whether they seek certification as Medi-Cal Peer Support Specialists or continue the delivery of Peer support in other ways. Certification of Medi-Cal Peer Support Specialists permits an additional pathway for Peer support within a standardized scope of work and code of ethics.

Certified Medi-Cal Peer Support Specialist Role

Peer Support services are provided by certified Medi-Cal Peer Support Specialists. Certified Medi-Cal Peer Support Specialists are individuals who are 18 years of age or older, who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of behavioral health treatment services or as a parent or family member of a consumer, and who have a current Peer Support Specialist

certification in California. The Peer Support Specialist serves as part of an integrated and/or multidisciplinary treatment team and offers an invaluable perspective on the most effective services to best support the recovery of the person in care. The role of the Peer Support Specialist is to offer support and therapeutic services based on shared understanding, respect, and mutual empowerment between people in similar situations. Their lived experience allows Peers to understand, support, and partner alongside persons in care and/or the person's significant support persons to support their recovery journey. Certified Medi-Cal Peer Support Specialists can provide unique prevention, early intervention, treatment, and recovery services.

Peer Support Services

Peer support services are culturally appropriate services that promote engagement, socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths. Medi-Cal Peer Support Specialist services include, but are not limited to, prevention services, support, coaching, facilitation, or education that is individualized and is conducted by a certified Medi-Cal Peer Support Specialist. Further, services should promote self-advocacy and support the identification of strengths. Peer support services may be provided with the person in care or significant support persons, with or without the person in care present, and aim to prevent relapse, empower persons in care through strengths-based coaching, support linkages to community resources, and educate the person in care and their significant supports about their mental health condition(s) and the process of recovery. Services that include the person's significant support persons remain focused on how to best support the person in care to reach their treatment goals. Case management services shall be provided including planning, finding, and accessing community resources and services, coaching, mentoring, facilitation, and/or psychoeducation. Services may be provided individually or in a group.

HEALTH CARE SYSTEMS

Health care systems are intended to help people improve or maintain their health and wellness within their community. For this to happen, people need to have the ability to access not just physical health care, but quality behavioral health care, in a way that is responsive to their particular needs and situation, respects their choices and authentically centers their voice.

We know from research that care is not always accessible, available, or responsive in an equitable way. Research further shows that access to and engagement in quality health care is affected by a number of factors, including race, ethnicity, socioeconomic status, and other social determinants. Social determinants of health (SDOH) play a huge part in people's health and wellness. SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH are grouped into five domains (CDC)[1]:

1. Economic stability (ability to access and maintain food, clothing, shelter, and mobility as well as other basic needs within their community)
2. Education (opportunities to learn and build skills)
3. Health care access and quality (to prevent and treat illness and injury)

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1   Social Determinants of Health | CDC; Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [May 2022], from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

4. Neighborhood and built environment (safe, free from pollutants and access to nature)
5. Social and community context and connectedness

SDOH contribute to health disparities and inequities simply by limiting access to fundamental resources aimed at supporting health and wellness. For example, if behavioral health services are offered in one part of town that is difficult to get to, those who live far away or have transportation challenges may not receive the services they need in a timely fashion. Or perhaps the same clinic does not employ direct service staff who speak the language or understand the culture of the person seeking care. This again impacts a person in care's ability to access care that meets their individualized needs. Lastly, we have witnessed the harsh realities of inequities revealed by the COVID-19 pandemic, with stark differences in outcomes including mortality seen along racial/ethnic lines, socioeconomic status, and educational attainment[2].

Although there are efforts aimed at addressing health disparities, there is still a lot of work to be done. As practitioners, we have a responsibility to look within our organizations and advocate for changes that help reduce or eliminate disparities within health systems. Through this diligent attention, systems can transform to best meet the needs of the people they are intended to serve. One of the monumental ways that CalAIM supports our systems in addressing health disparities is in the acknowledgment of the impact of trauma on health and wellness. We are able to streamline access to service, especially for youth, when a substance SUD is suspected but not yet diagnosed, or due to trauma. Details on this access criteria will be addressed later in this manual, as it cues practitioners in the way that treatment services can be initiated while assessment is occurring concurrently.

Social Determinants of Health

Education Access and Quality

Health Care Access and Quality

Economic Stability

Neighborhood and Built Environment

Social and Community Context

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3   https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786466

MEDI-CAL PROGRAMS

In California, the Department of Health Care Services (DCHS) is the state agency responsible for the administration of the state's Medicaid program. In California, we refer to Medicaid as "Medi-Cal." The Medi-Cal program is a mix of federal and state regulations serving over 13 million people, or 1/3 of all Californians. Medi-Cal covers 40% of children and youth and 43% of individuals with disabilities in California.[3]

Medi-Cal behavioral health services are "carved out", meaning that they are delivered through separate managed care delivery systems, each of which is responsible for delivering different sets of services to individuals depending on their care needs.

To keep it simple, we will look at the three managed care plans; Mental Health Plans (MHP) operated by county behavioral health departments, Drug Medi-Cal Plans (DMC or DMC-ODS) administered respectively by the state or the county, and Managed Care Plans (MCP) physical healthcare plans. The MCPs, which are operated by either publicly run or commercial entities, also administer the Non-Specialty Mental Health Services (NSMHS)benefit.

County				State
MCP	MCP	MHP	DMC-ODS/DMC	Dental
Physical Healthcare	Non-Specialty Mental Health	Specialty Mental Health	Substance Use Treatment Services	Dental

Mental Health Plans

Specialty Mental Health Services (SMHS) are managed locally by county Mental Health Plans (MHPs). Fifty-six county MHPs are contracted with DHCS to administer the Medi-Cal SMHS benefit. In addition to managing the benefit, MHPs directly deliver and/or contract with Community-Based Organizations (CBOs) or groups/individual providers to deliver an array of services designed to meet the needs of individuals with Medi-Cal who have significant and/or complex care needs. This array includes highly intensive services and programs, including therapy, community-based services, wraparound, and intensive case management programs. The term "case management" is used at different points since this service type is defined in federal regulation for SMHS. However, it is important to remember that each person in care is not a "case" to be managed, but rather a human being with care needs. (See Appendix II for a list of covered services.)

SMHS are provided to persons with mental health conditions that require intervention to support the person's ability to safely participate in their communities and achieve wellbeing. The Medi-Cal populations served by county MHPs include elderly, disabled, adults, youth and foster or probation youth near or below federal poverty levels with mental health conditions or trauma significantly impairing their ability to successfully participate in their communities. In short, MHPs serve some of the most vulnerable populations.

Drug Medi-Cal and the Drug Medi-Cal Organized Delivery System

Within the broader Medi-Cal program, DHCS administers the Drug Medi-Cal (DMC) Program. DMC reimbursement is issued to counties and direct providers that have a contract with

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3   https://www.chcf.org/publication/2021-edition-medi-cal-facts-figures/

DHCS for approved DMC services provided to Medi-Cal beneficiaries. Persons in care who are eligible for DMC services include individuals eligible for federal Medicaid, for whom services are reimbursed from federal, state, and/or county realignment funds. Such services include Narcotic Treatment Program (NTP), Outpatient Drug Free (ODF) individual and group, Intensive Outpatient (IOP), Perinatal Residential and Naltrexone Treatment. In order for Drug Medi-Cal to pay for covered services, eligible Medi-Cal members must receive substance use disorder (SUD) services at a Drug Medi-Cal certified program.

Drug Medi-Cal – Organized Delivery System (DMC-ODS) is a program for the organized delivery of substance use disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS.5 Counties participating in the DMC-ODS program provide their resident Medi-Cal beneficiaries with a range of evidence-based SUD treatment services in addition to those available under the Drug Medi-Cal (DMC) program. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care. To receive services through the DMC-ODS, a person must be enrolled in Medi-Cal, reside in a participating county, and meet the criteria for DMC-ODS services.

Managed Care Plans

Managed Care Plans (MCPs) are responsible for the majority of medical (physical health care) benefits and NSMHS for individuals. The MCPs provide mental health services to those with less significant or complex care needs, so may provide lower frequency/intensity of mental health services. MCPs cover medication evaluation and treatment, group and individual therapy, psychological testing, and long-term skilled nursing services as well as prescription medications, including psychotropic medications (See Appendix II for a list of covered services.) There are 24 MCPs across 58 counties delivering services across a managed network of providers (individual professionals or agencies). Some counties may have multiple MCPs in one county and individuals with Medi-Cal can choose which MCP they would like to belong to. In other counties, there may be a single MCP providing coverage to all individuals with Medi-Cal. To find out which MCPs provide coverage in your county, check the DHCS website, linked here for convenience.

All three plan types discussed here - MHPs, DMC State Plan/DMC-ODS and MCPs administer and deliver an array of services to Medi-Cal members. Given the complexity of the systems, it can be difficult for individuals seeking services to understand which plan would best treat their behavioral health care needs and where/how to access SMHS, DMC or NSMHS. CalAIM provides new guidelines for accessing medically necessary care.

DEFINITION OF MEDICAL NECESSITY

All Medi-Cal services provided to persons in care need to meet the standard of being "medically necessary". The definitions of medical necessity are somewhat different, based upon the age of the person in care. For individuals age 21 and older, a mental health service is considered "medically necessary" when it is "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." For individuals under age 21, the definition of whether a mental health service is considered "medically necessary" falls under the Early and Period Screening, Diagnostic and Treatment (EPSDT)

Services language under a specific section of Title 42[4]. This section requires provision of all Medicaid (Medi-Cal) coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not the service is covered under the State Plan. These services need not be curative or restorative, and can be delivered to sustain, support, improve or make more tolerable a mental health condition.

ACCESS TO THE SPECIALTY MENTAL HEALTH SERVICES (SMHS) SYSTEM

In a previous section, we described covered services under the MHP Medi-Cal benefit. Next, we will discuss the criteria for accessing specialty mental health services (SMHS) through the MHP. While we will be discussing the technical criteria, we encourage practitioners to continue to review the information from the perspective of the person in care with empathy and centering the person's voice regarding their health care decisions.

The criteria we will discuss in this section are for two distinct age cohorts: individuals aged 21 years and older and individuals under 21 years of age. Each of these cohorts have distinct criteria due to their developmental needs.[5] It is important to point out early that a person may begin to receive clinically appropriate services, so long as the person would benefit from the SMHS services, even before a diagnosis has been fully articulated and a final determination has been made.

Overview of criteria for persons aged 21 years and older

- The person has significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in important area of life functioning

- AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.

Overview of criteria for persons under 21 years of age

- The person is experiencing homelessness, and/or is interacting with the child welfare or criminal justice system

- OR has scored high on the trauma screening tool, placing them at high risk for a mental health disorder.[6]

- OR, the person has a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing as developmentally appropriate, or there is no presence of impairment

- AND the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.

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4   Section 1396d(r) of Title 42 of the United States Code.

5   DHCS Behavioral Health Information Notice (BHIN) No: 21-073

6   Specific information on the trauma screening tools, scoring and thresholds for access criteria will be provided by DHCS at a later date

| Screening	Assessment	Problem List	Care Coordination	Treatment	Care Transitions	Discharge

SCREENING TOOLS

Persons needing care may access care in several different ways including self-referral, getting a referral from another behavioral health practitioner, or a primary health care provider, etc. No matter how a person initiates care, the person can expect to receive timely mental health services whether from an MHP or through the MCP. If we keep the person's care needs at the forefront of treatment decisions, there is no wrong door by which the person may enter. The goal is to ensure that individuals seeking care have access to the right care in the right place at the right time, regardless of what door they come to initially.

Screening is used as the first step in getting the person connected with the right care in the system. Screening may or may not be completed by an LPHA [7]. When an individual seeks care, the standard "Screening Tool" is used to understand the person's needs and get them to the provider that best matches their needs. The screening tools may be completed in person, by phone, or in a community setting. The screening tools do not replace the need for an assessment, which will come later. The screening tools, one for individuals under the age of 21 (youth) and one for individuals over the age of 21 (adult), are used to help identify behavioral health needs, symptoms, and distress.

These screening tools are intended to be used by the MHP and MCP service delivery systems by a diverse workforce and were designed for use by non-clinical staff (e.g., Access lines, hotlines, intake staff) to determine the best place for a person to start care (MCP, MHP, or SUD delivery system). The screening tools are intentionally brief, as they are completed in one encounter in order to determine which service delivery system is a more appropriate fit. In instances where serious risk factors are identified (danger to self, danger to others, etc.), the individual administering the tool is expected to immediately contact appropriate staff within their MHP (or emergency services if warranted) to conduct a more in-depth risk evaluation, including crisis supports.

Once the screening tool has been administered, there may be a referral for an assessment by an LPHA to develop a clinical understanding regarding the person's care needs, including diagnosis, and to confirm the appropriate treating system and what services are medically necessary. Because humans are complex, the assessment may take more than one session to fully determine the overall care needs. For many individuals and/or in some circumstances, assessment also includes the collection of information from collateral sources including, but not limited to, family members, prior service providers and/or system partners. While the assessment is in process, the person in care may also receive clinically appropriate services simultaneous to the assessment services.

Screening

Mild | Moderate | Severe

Assessment

Treatment

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[7] "Licensed Practitioner of the Healing Arts" in this context means licensed, registered or waivered psychologists, clinical social workers, marriage and family therapists or professional clinical counselors. Psychiatrists and nurses are also LPHAs; however, they have different scopes of practice.
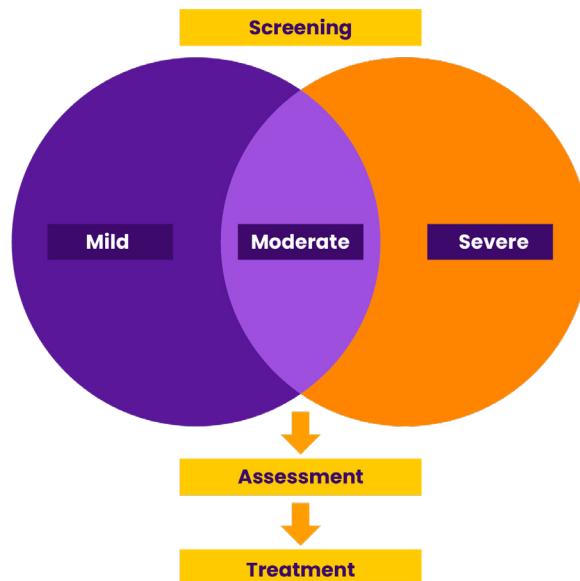
Clinically appropriate services include prevention, screening, assessment, and treatment services (e.g., therapy, rehabilitation, collateral, case management, medication support) and are covered and reimbursable under Medi-Cal even when[8]:

1. Services are provided prior to determination of a diagnosis, during the assessment process, or prior to determination of whether SMHS access criteria are met;

    •   While a mental health diagnosis is not a prerequisite for access to covered services and while a person may access necessary services prior to determining a diagnosis, a provisional diagnostic impression and corresponding ICD-10[9] code must be assigned to submit a service claim for reimbursement. There are ICD-10 codes LPHAs may use prior to the determination of a diagnosis – if there is a suspected disorder within the LPHA's scope, "Other Specified" or Unspecified" ICD-10 codes are available. Additionally, the code Z03.89 "Encounter for observation for other suspected diseases and conditions ruled out" may be used.

    •   As appropriate, LPHAs and non-LPHAs alike may use ICD-10 codes Z55-Z65 "Persons with potential health hazards related to socioeconomic and psychosocial circumstances[10].

2. The person in care has a co-occurring mental health condition and substance use disorder (SUD); or

3. Non-specialty mental health services (NSMHS) and specialty mental health services (SMHS) are provided concurrently, if those services are coordinated and not duplicative.

We should note that the responsibilities for covered services by each of the service delivery systems remains in place, with each delivery system responsible for providing covered services per its contract with DHCS. This remains true even when persons in care are receiving services from multiple delivery systems, as each delivery system has separate and distinct services for which it provides coverage.

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8   Welfare & Institutions Code 14184.402(f)

9   https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf and https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

10 https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf and https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

STANDARDIZED ASSESSMENT

The goal of an assessment is to understand the person's needs and circumstances, in order to recommend the best care possible and help the person recover. The assessment must be completed under the guidance of an LPHA. It may be acceptable in some instances for a Certified Peer Support Specialists to offer support to the person in care during the assessment process and/or may share information with the treatment team through collaboration. 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[11] and their ability to thrive in their community. An assessment may require more than one session to complete and/or may 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 to gather a cohesive understanding of the person's care needs. Services to support the person's ability to remain safe and healthy in the community are of utmost importance. Therefore, it is important that practitioners ensure that the assessment process begins with risk and safety discussions, then moves on to discuss other matters of urgency to the person in care and completes assessment activities by gathering background information that impacts the primary concerns of the person in care.

Many different tools or tests are available to assess different aspects of a person's functioning, such as tools to assess trauma, depression, suicide risk, and mental status. While the use of tools is often left to the discretion of the assessing practitioner, it is the practitioner's responsibility to use the tool for its intended purpose and to have the appropriate training for administration and scoring of the tool. Note that some tools must be completed by clinicians, while others may be completed by other types of staff, including Certified Peer Support Specialists. Information or results from the tools utilized should be included as part of the assessment.

DHCS requires practitioners to complete an assessment for the determination of behavioral health needs. While all persons shall receive a mental health assessment to best determine their individual needs, there are different assessments to meet this requirement, based on age and type of service being sought.

- Assessments for mental health services for adults aged 21 years and older shall cover all the domains listed in the section below.
- The Child and Adolescent Needs and Strengths (CANS-50) and Pediatric Symptom Checklist (PSC-35) may be used to inform the assessment domain requirements for persons aged 5 through 20 (for CANS) and persons aged 4 through 17 (PSC).
- Assessments for substance use disorders for persons of all ages shall use the American Society of Addiction Medicine (ASAM) criteria when determining level of care.

Central to the completion of a comprehensive assessment is collaboration with the person in care. Centering the voice of the person in care and remaining curious and humble about the person's experiences, culture and needs during the assessment process is crucial to building this collaboration. When assessments are conducted in this manner, they function as an important intervention and relationship building opportunity. Focusing on strengths, culture, and resiliency, in addition to challenges, creates a setting where the person in care feels seen

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[11]   California Code of Regulations, Title 9, Chapter 11, Section 1810.204

as a whole person. Assessments must be approached with the knowledge that one's own perspective is full of assumptions, so that staff maintain an open mind and respectful stance towards the person in care.

Curiosity and reflection indicate humility and a deep desire to truly understand the person in care and to help them meet their needs. A key outcome of the assessment process is the generation of shared agreement on the strengths and needs of the person in care, as well as how to best address those needs. The assessment process generates a hypothesis, developed in collaboration with the person in care, that helps to organize and clarify service planning.

Standardized Assessment Requirements (Including Timeliness)

A. SMHS

   a. MHPs shall require providers to use uniform assessment domains as identified below. For persons in care under the age of 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the assessment domain requirements.

   b. 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.

   c. Services provided prior to determination of a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met are covered and reimbursable, even if the assessment ultimately indicates the person does not meet criteria for SMHS.

   d. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature.

   e. The assessment shall include the provider's recommendation – and determination of medical necessity for services. The problem list and progress note requirements identified below shall support the medical necessity of each service provided.

   f. The diagnosis, Mental Status Exam (MSE), medication history, and assessment of relevant conditions and psychosocial factors affecting the person's physical and mental health must be completed by a provider, operating in their scope of practice under California State law, who is licensed, registered, waivered, and/or under the direction of a licensed mental health professional as defined in the State Plan[12].

   g. The Mental Health Plan (MHP) may designate certain other qualified providers to contribute to the assessment, including gathering the person's mental health and medical history, substance exposure and use, and identifying strengths, risks, and barriers to achieving goals[13].

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12   https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supp1toAtt3.1-A98-16%20(10-012B).pdf

13   https://www.law.cornell.edu/regulations/california/9-CCR-Sec-1840-334#:~:text=Code%20Regs.-,Tit.,Services%20Contact%20and%20Site%20Requirements&text=(a)%20Crisis%20Residential%20Treatment%20Services,be%20delivered%20at%20that%20site; https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement_3_to_Attachment_3.1-A.pdf; https://www.dhcs.ca.gov/Documents/Supplement-2-to-Attachment-3-1-B-2-4-22.pdf

Assessment Domain Requirements[14]

The assessment contains universally required domains (ASAM Criteria) that should not vary from county to county or CBO to CBO. Below is information on the standardized ASAM Criteria comprising the assessment for understanding the person's care needs. While each of the dimensions are required and must be addressed, information may overlap across dimensions. 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 in care and, whenever possible, quote their own words within the document.

Below are the domain categories, key elements, and guidance on information to consider under each domain. The information in the outline below is not meant to be an exhaustive list. The practitioner should always consider the person within the context of their developmental growth and their larger community, including cultural norms or expectations when completing and documenting an assessment. Information within the assessment should come from the person seeking care, in their own words whenever possible. Particularly for children/youth and those with disabling impairments, this may also include information from collateral sources.

| Presenting Problem | Trauma | Behavioral Health History | Medical History | Psychosocial factors | Strengths/Risks | Clinical Summary |
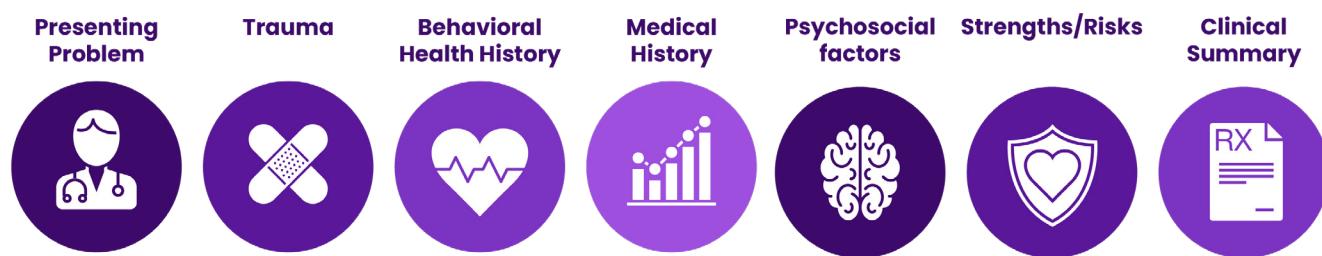
Presenting Problem/Chief Complaint (Domain 1)

Domain 1 focuses on the main reason the person is seeking care, in their own words if appropriate. The goal is to document an account of what led up to seeking care. This domain addresses both their current and historical states related to the chief complaint.

- *Presenting Problem (Current and History of)* – *The person's and collateral sources' descriptions of problem(s), history of the presenting problem(s), impact of problem on person in care. Descriptions should include, when possible, the duration, severity, context and cultural understanding of the chief complaint and its impact.*

- *Current Mental Status Exam* – *The person's mental state at the time of the assessment.*

- *Impairments in Functioning* – *The person and collateral sources identify the impact/ impairment – level of distress, disability, or dysfunction in one or more important areas of life functioning as well as protective factors related to functioning. Functioning should be considered in a variety of settings, including at home, in the community, at school, at work and with friends or family.*

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14   WIC 14184.402(c) and 402(d)

Trauma (Domain 2)

Domain 2 involves information on traumatic incidents, the person in care's reactions to trauma exposures and the impact of trauma on the presenting problem. It is important that traumatic experiences are acknowledged and integrated into the narrative. Take your cues from the person in care — it is not necessary in every setting to document the details of traumatic incidents in depth.

- *Trauma Exposures* – *A description of psychological, emotional responses and symptoms to one or more life events that are deeply distressing or disturbing. This can include stressors due to significant life events (being unhoused or insufficiently housed, justice involvement, involvement with child welfare system, loss, etc.)*

- *Trauma Reactions* – *The person's reaction to stressful situations (i.e., avoidance of feelings, irritability, interpersonal problems, etc.) and/or information on the impact of trauma exposure/history to well-being, developmental progression and/or risk behaviors.*

- *Trauma Screening- The results of the trauma screening tool to be approved by DHCS (e.g., Adverse Childhood Experiences {ACEs}), indicating elevated risk for development of a mental health condition.*

- *Systems Involvement* – *The person's experience with homelessness, juvenile justice involvement, or involvement in the child welfare system.*

Behavioral Health History (Domain 3)

Domain 3 focuses on history of behavioral health needs and the interventions that have been received to address those needs. Domain 3 also includes a review of substance use/abuse to identify co-occurring conditions and/or the impact of substance use/abuse on the presenting problem.

- *Mental Health History* – *Review of acute or chronic conditions not earlier described. Mental health conditions previously diagnosed or suspected should be included.*

- *Substance Use/Abuse* – *Review of past/present use of substances, including type, method, and frequency of use. Substance use conditions previously diagnosed or suspected should be included.*

- *Previous Services* – *Review of previous treatment received for mental health and/or substance abuse concerns, including providers, therapeutic modality (e.g., medications, therapy, rehabilitation, hospitalizations, crisis services, substance abuse groups, detox programs, Medication for Addiction Treatment[MAT]), length of treatment, and efficacy/response to interventions.*

Medical History and Medications (Domain 4)

Domain 4 integrates medical and medication items into the psychosocial assessment. The intersection of behavioral health needs, physical health conditions, developmental history, and medication usage provides important context for understanding the needs of the people we serve.

- *Physical Health Conditions* – *Relevant current or past medical conditions, including the treatment history of those conditions. Information on help seeking for physical health treatment should be included. Information on allergies, including those to medications, should be clearly and prominently noted.*

- *Medications* – *Current and past medications, including prescribing clinician, reason for medication usage, dosage, frequency, adherence, and efficacy/benefits of medications. When available, the start and end dates or approximate time frames for medication should be included.*

- *Developmental History* – *Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger).*

Psychosocial Factors (Domain 5)

Domain 5 supports clinicians in understanding the environment in which the person in care is functioning. This environment can be on the micro-level (e.g., family) and on the macro-level (e.g., systemic racism and broad cultural factors).

- *Family* - *Family history, current family involvement, significant life events within family (e.g., loss, divorce, births)*

- *Social and Life Circumstances* – *Current living situation, daily activities, social supports/ networks, legal/justice involvement, military history, community engagement, description of how the person interacts with others and in relationship with the larger social community*

- *Cultural Considerations* – *Cultural factors, linguistic factors, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning and other (LGBTQ+) and/or Black, Indigenous and People of Color (BIPOC) identities, gender identifications, spirituality and/or religious beliefs, values, and practices*

Strengths, Risk and Protective Factors (Domain 6)

Domain 6 explores areas of risk for the individuals we serve, but also the protective factors and strengths that are an equally important part of the clinical picture. Clinicians should explore specific strengths and protective factors and understand how these strengths mitigate risks that the individual is experiencing.

- *Strengths and Protective Factors* – *personal motivations, desires and drives, hobbies and interests, positive savoring and coping skills, availability of resources, opportunities and supports, interpersonal relationships*

- *Risk Factors and Behaviors* – *behaviors that put the person in care at risk for danger to themselves or others, including suicidal ideation/planning/intent, homicidal ideation/ planning/intent, aggression, inability to care for self, recklessness, etc. Include triggers or situations that may result in risk behaviors. Include history of previous attempts, family history of or involvement in risks, context for risk behaviors (e.g., loneliness, gang*

affiliations, psychosis, drug use/abuse), willingness to seek/obtain help. May include specific risk screening/assessment tools (e.g., Columbia Suicide Severity Rating Scale) and the results of such tools used

- *   **Safety Planning** *– specific safety plans to be used should risk behaviors arise, including actions to take and trusted individuals to call during crisis.*

Clinical Summary, Treatment Recommendations, Level of Care Determination (Domain 7)

Domain 7 provides clinicians an opportunity to clearly articulate a working theory about how the person in care's presenting challenges are informed by the other areas explored in the assessment and how treatment should proceed based on this hypothesis.

- *   **Clinical Impression** *– <u>summary</u> of clinical symptoms supporting diagnosis, functional impairments (clearly connected to symptoms/presenting problem), history, mental status exam, cultural factors, strengths/protective factors, risks, and any hypothesis regarding predisposing, precipitating and/or perpetuating factors to inform the problem list (to be explained further below)*
- *   **Diagnostic Impression** *– clinical impression, including any current medical diagnoses and/or diagnostic uncertainty (rule-outs, provisional or unspecified)*
- *   **Treatment Recommendations** *– recommendations for detailed and specific interventions and service types based on clinical impression and, overall goals for care.*[15] [16]

Diagnosis

Information for the determination of a diagnosis is obtained through a clinical assessment and may include a series of structured tools. Information may come directly from the person in care or through other means, such as collateral information or health records. A diagnosis captures clinical information about the person's mental health needs and other conditions based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). Diagnoses are determined by an LPHA commensurate with their scope of practice (see Appendix III for scope of practice grid). Diagnoses are used to communicate with other team members about the person's mental health symptoms and other conditions and may inform level of distress/impairment. Moreover, and most importantly, diagnoses may help practitioners advise the person in care about treatment options.

Diagnoses should not remain static. For example, the person's clinical presentation may change over time and/or the practitioner may receive additional information about the person's symptoms and how the person experiences their symptoms(s) and conditions. As a Peer Support Specialist, it is your responsibility to collaborate with clinicians as they document all diagnoses, including preliminary diagnostic impressions and differential diagnoses. Additionally, Peer Support Specialists should collaborate with the clinician when they believe a person in care's symptoms have changed so that the health record may be updated accordingly.

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15 BHIN 21-071 (ca.gov)
16 BHIN21-073 (ca.gov)

While there is no longer a limited set of diagnosis codes that are allowable in relation to the provision of SMHS, the responsibilities of the MHPs related to the MCPs remain unchanged. For example, MHPs are not required to provide Applied Behavior Analysis (ABA), a key intervention in the treatment of Autism Spectrum Disorder (ASD), as that responsibility still lies with the MCP. However, a person in care who has ASD is able to additionally receive treatment from the MHP if their service needs require it and are not duplicative.

Providers may use the following options during the assessment phase of a person's treatment when a diagnosis has yet to be established[17]:

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate, including Certified Peer Support Specialists, 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 person'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[18]. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

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17   https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf

18   https://www.dhcs.ca.gov/Documents/BHIN-22-013-Code-Selection-During-Assessment-Period-for-Outpatient-Behavioral-Health.pdf and https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

| Screening	Assessment	Problem List	Care Coordination	Treatment	Care Transitions	Discharge

THE PROBLEM LIST

In the previous section we explored the assessment and how it informs care recommendations. Next, we will explore how the diagnosis/diagnoses and the problem list intersect. Below you can see how different members of the care team can add to the list to fully capture the issues needing attention.

The use of a Problem List has largely replaced the use of treatment plans[19], except where federal requirements mandate a treatment plan be maintained. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the service provider during that service encounter, and subsequently added to the problem list. The providers responsible for the person's care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by Mental Health Rehabilitation Specialists, Peer Support Specialists, and other treatment team members. The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person's care needs, including current diagnoses and key health and social issues.
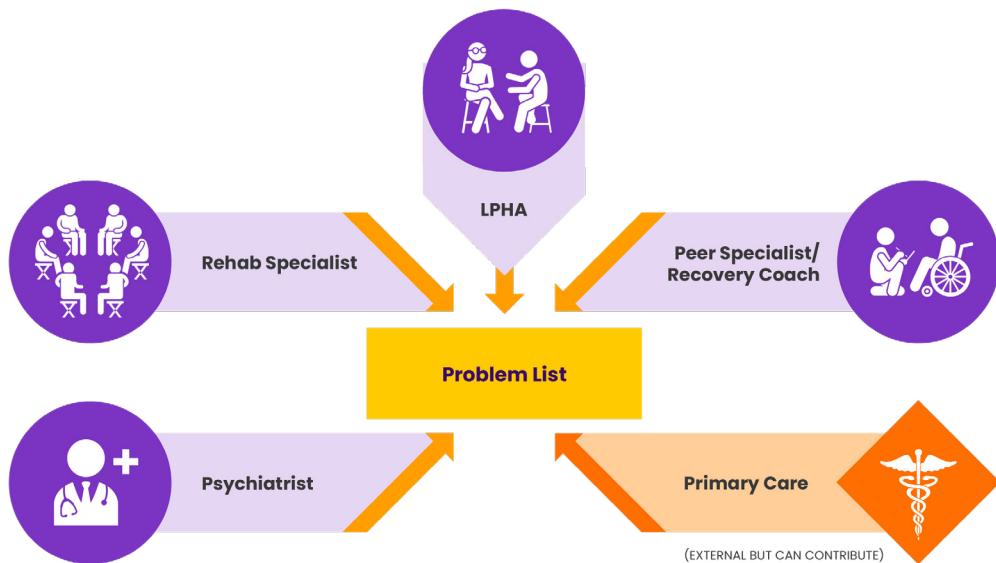
When used as intended, treatment teams can use the problem list to quickly gain necessary information about a person's concerns, how long the issue has been present, the name of the practitioner who recorded the concern, and track the issue over time, including its resolution. The problem list is a key tool for treatment teams and should be kept up to date to accurately communicate a person's needs and to support care coordination.

Problem lists will have DSM diagnosis codes, including Z codes, as well as the DHCS Priority SDOH codes[20]. See Appendix IV for a list of DHCS SDOH Priority Codes.

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19 Treatment or Care Plans remain in place for some specialty programs, per BHIN 22-019, Attachment 1 https://www. dhcs. ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf

20 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-009.pdf

Problem List Requirements

The problem list shall be updated on an ongoing basis to reflect the current presentation of the person in care.

The problem list shall include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice, if any.
  - Include diagnostic specifiers from the DSM if applicable.
- Problems identified by a provider acting within their scope of practice, if any.
- Problems or illnesses identified by the person in care and/or significant support person, if any.
- The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Providers shall add to or remove problems from the problem list when there is a relevant change to a person's condition.

DHCS does not require the problem list to be updated within a specific time frame or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, providers shall update the problem list within a reasonable time and in accordance with generally accepted standards of practice.

Accuracy of the diagnoses and problem list are necessary for appropriate treatment services to a person, and to support claiming for services. Inconsistencies in either can lead to poor coordination of care across teams and treatment as well as inadequate documentation of the medical necessity of services, which can lead to rejected claims.

Treatment Plan Requirements

In the past, treatment plans were static and complicated documents with strict start and end dates. If services were provided that were not documented on the treatment plan, they could not be claimed. Persons in care had to sign the treatment plans or they were not considered valid. Over time it has become clear that effective treatment planning involves a more dynamic process since the person's needs are dynamic and can change rapidly. As part of CalAIM, treatment plans for many types of services are moving from standalone documents to be embedded in progress notes. Exceptions to these changes can be found in Attachment 1 of BHIN 22-019[21].

A. Targeted Case Management (TCM)

Targeted case management services within SMHS require the development (and periodic revision) of a specific care plan that is based on the information collected through the assessment. The TCM care plan:

- Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational and other services needed by the person in care;
- Includes activities such as ensuring the active participation of the person in care, and working with the person (or the person's authorized health care decision maker) and others to develop those goals;

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21   https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf

- Identifies a course of action to respond to the assessed needs of the person in care; and
- Includes development of a transition plan when a person in care has achieved the goals of the care plan.

These required elements shall be provided in a narrative format in the person's progress notes.

B. Peer Support Services

Peer support services must be based on an approved care plan[22]. The care plan shall be documented within the progress notes in the person's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

C. Additional Treatment/Care Planning Requirements

Requirements for treatment/care planning for additional service types are found in Attachment 1 of BHIN 22-019[23].

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22 https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd081507a.pdf; https://www.dhcs.ca.gov/ formsandpubs/laws/Documents/Att-3-1-A-Supp-3.pdf

23 https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf

Example of a Person in Care's Problem List:

Number	Code	Description	Date Added	Date Removed	Identified by	Provider Type
1	Z65.9	Problem related to unspecified psychosocial circumstances	07/01/2022	07/19/2022	Name	Mental Health Rehabilitation Specialist
2	Z59.02	Unsheltered homelessness	07/01/2022	Current	Name	AOD Counselor
3	Z59.41	Food insecurity	07/01/2022	Current	Name	Peer Support Specialist
4	Z59.7	Insufficient social insurance and welfare support	07/01/2022	Current	Name	Peer Support Specialist
5	F33.3	Major Depressive Disorder recurrent, severe with psychotic features	07/19/2022	Current	Name	Psychiatrist
6	F10.99	Alcohol Use Disorder, unspecified	07/19/2022	Current	Name	Clinical Social Worker
7	I10.	Hypertension	07/25/2022	Current	Name	Primary Care Physician
8	Z62.819	Personal history of unspecified abuse in childhood	08/16/2022	Current	Name	Clinical Social Worker

Screening	Assessment	Problem List	Care Coordination	Treatment	Care Transitions	Discharge

CARE COORDINATION

In the previous sections, we explored social determinants of health and their contribution to quality of life based on access to resources. Access to health care requires services to be available and accessible at the time the person needs the services. It also requires practitioners to work alongside the person in care throughout their health care journey and to take a stance of curiosity and ask meaningful questions aimed at understanding the person within the context of their culture, community, and help seeking behaviors. By doing so, we are in better alignment with developing care and treatment recommendations that support a person-centered approach. However, as practitioners, we must further support the access to other

necessary resources through coordination efforts across systems and providers, while keeping the person in care as the central and most important voice on the team.

Care coordination is necessary, requiring the practitioner to be intentional and informed about coordinating activities or services with other providers to best meet the person in care's needs. We know far too well that accessing and navigating healthcare systems can be a challenge for anyone. This may be especially true in behavioral health because care coordination involves treatment providers across multiple disciplines and organizations. A person may receive care by multiple providers within the MHP or other external entities, all at the same time. To ensure smooth coordination of care, practitioners should request authorization to share information (also known as releases of information) for all others involved in the care of the person in treatment during the intake process and throughout the course of treatment.

Care coordination also meets federal requirements to ensure that each person in care has an ongoing source of care appropriate to their needs. Additionally, a person or entity must be formally designated as primarily responsible for coordinating the services accessed by the person in care. The person in care must be provided information on how to contact their designated person or entity.[24]

Care coordination benefits from a point person who is accountable for coordination, bringing the person in care, natural supports/family, all service providers and system partners to the table. The Care Coordinator may be you, a treatment team member from your organization, or a treatment provider from another organization or delivery system. This role may have different names within various organizations, such as case manager, care manager, team facilitator, or the function of care coordination may be incorporated into the role of a clinician or other staff. The main goal of the Care Coordinator is to meet the person's care needs by using care information in a deliberate way and sharing necessary information with providers and the person in care, to guide the delivery of appropriate and effective care. Care coordinators work to build teams and facilitate partnerships, creating formal and informal networks of support that enhance treatment for persons in care and allow for sustainable support long after treatment ends. Care coordination serves as a key element of service planning, ensuring that treatment across the team is meeting the needs of the person in care, that plans are updated as needed and that barriers to success are overcome. Within the team, communication is a key element of success, along with empowering the person in care to guide the team to meet their own needs. When referring or transitioning a person in care, the practitioner should discuss the reason for referral or transition and ensure the person understands, not only the reason for referral or transition, but also the expected outcome of the referral or transition. In January 2023, DHCS will launch a universal tool for transitioning between MHPs and MCPs to assist with care coordination and communication during transitions.

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24   42 CFR §438.208

| Screening | Assessment | Problem List | Care Coordination | Treatment | Care Transitions | Discharge |

TREATMENT

Stages of Change

While the assessment, diagnosis, and problem list are necessary to understanding the person's overall care needs, equally as important is the consideration of the stage in which the person is in their recovery. The Stages of Change[25] framework supports practitioners in meeting the person where they are. Their readiness for change offers empowerment to the person. This framework lends itself to the identification of evidence-based interventions compatible with each stage of change and supports the conceptualization of change as a continuum. Change is not considered a linear process and should be evaluated throughout the course of care.

Moreover, a person may be in different stages of change relative to each issue. Movement from stage to stage may vary per person and may, at times, move backwards in addition to forwards through the stages. Some persons may move faster than others, while others may plateau in one stage for a longer period. A practitioner may take this opportunity to engage the person in understanding the situation.

We should note, relapse or reversion in symptoms, behaviors and/or functioning is a normal part of the change process. When relapse occurs, practitioners should take time to evaluate the situation alongside the person in care and continue to encourage and explore pros and cons of changes. Next, let us explore the framework.

Stage	Description	Potential Behaviors
Precontemplation	This is the period prior to any action towards change. The person has not yet begun to think about change. Person is not aware they have a problem.	Seeking services due to pressure of others (i.e., parent, partner, employer, courts). Place responsibility of problems on other factors or persons.
Contemplation	Person is aware they have a problem. During this period, the person begins to consider the possibility of change and begins to evaluate the benefits of making change. Not fully dedicated to taking action.	Considerations of the pros and cons of change are weighed. Action may take place if pros outweigh cons. Planning may take place the next few months.
Preparation	Person begins planning to make changes to what they are most committed to. Adjustments begin toward making change.	Person is future thinking and focused on their commitment.

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25   Prochaska, J.O, & DiClemente, C.C. (1982). Transtheoretical therapy: Toward a more integrative model of change. Psycho- therapy: Theory, Research and Practice, 19, 276-287.

Action	Specific changes to aspects of life that are contributing to undesired situation or problem. Changes may be behavioral or environmental. Changes may include decreasing unhealthy behaviors or increasing healthy ones.	Person is actively modifying their behaviors and is committed to change.
Maintenance	Actively working to sustain previously changed behaviors.	Person is committed to maintaining changes. Requires strong commitment of the person to avoid reverting to previous behaviors. Person has strong supports, including community connectedness.

Motivational Interviewing

Built on the Stages of Change model, service providers tend to find that principles of Motivational Interviewing (MI)[26] align closely with the person in care's treatment needs, is applicable in a broad range of settings and works well in combination with other common clinical practices. MI is an approach that addresses the comprehensive needs of people in care, views the person in care as an equal partner in the therapeutic process and integrates a focus on moving through the stages of change to support building motivation. People in care develop insight and skills through the use of focused MI interventions when service providers meet the individual where they are in their thinking about change and believe that people are the experts in their own lives.

Service providers use MI styles of communication to demonstrate respect and curiosity in ways that empower people in care to move through the recovery process. People in care experience incremental success and, through each step towards goal attainment, develop confidence in their ability to recover from their mental health and/or substance use challenges. In the MI model, the person in care, rather than the service provider, should present the arguments for change. This happens through a variety of strategic responses focused on enhancing the individual's understanding of change and building intention towards change. Individuals are invited to new perspectives, but these perspectives are not imposed on the person in care.

Service providers support individuals in moving through the Stages of Change through four widely applicable processes:

1. Engaging

- Accepting people as they are in order to free them to change
- Employing acceptance and respect, normalize ambivalence and affirm strengths

2. Focusing

- Development of shared purpose
- Assessing how important the person in care thinks change is in their life – life goal analysis, values exploration, discrepancy development.

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26   https://motivationalinterviewing.org/understanding-motivational-interviewing

3. Evoking

- Building the case for change – developing a "why"
- Exploration of ambivalence and change talk

4. Planning

- Development of plans for change – exploration of the "how"
- Supporting self-efficacy and exploring previous successes the person in care has experience to increase their confidence in their ability to change.

MI is especially useful when a person in care is in the pre-contemplation and contemplation stages of change. As is true with other EBPs, it is vital that a person is not only well-trained in MI, but also continues to receive supervision, consultation, or mentorship to ensure that it is performed with fidelity to the model.

Treatment Services

Medi-Cal SMHS are comprised of a variety of treatment services provided to individuals, groups and/or families. A list and definition of the primary service types are below.

Assessment: Service activity which may include a clinical analysis of the history and current status of a person in care's mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and the use of testing procedures.

Plan Development: Service activity which consists of development of plans, approval of plans, and/or monitoring of a person in care's progress.

Peer Support Services: Services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. Services may be provided to the individual or in a group setting. Services may be provided directly to the person in care and/or their support systems to help the person in care achieve desired outcomes.

- **Educational Skill Building Group:** Services that promote coping mechanisms and problem-solving skills in areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports. The focus may be on skill development and/or acquisition of skills.

- **Engagement:** Services include activities and coaching to encourage and support the person in care to participate in behavioral health treatment, including support through transitions of care and development of recovery goals and processes.

- **Therapeutic Activities:** Services include structured activities that promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and maintenance of community living skills to support he person in care attain and maintain recovery within their communities. Activities include, but not limited to, advocacy, promotion of self-advocacy, resource navigation, and collaboration with significant supports, family, and other providers of care.

Targeted Case Management (Case Management/ Brokerage/Linkage): Services that assist a person in care to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure access to service and the service delivery system; monitoring of individual progress.

Intensive Care Coordination (ICC): Service that is responsible for facilitating assessment, care planning, and coordination of services, including urgent services, to foster and/or probation involved youth. Includes work within the Child & Family Team (CFT) to ensure that plans from any of the system partners (mental health, child welfare, education services, probation, etc.) are integrated to comprehensively address goals and objectives. Also includes facilitation and participation in CFTs and team coordination to ensure participation by the child or youth, family or caregiver and other natural or paid supports so that the assessment and plan addresses the child or youth's needs and strengths in the context of the values and philosophy of the Pathways to Mental Health Core Practice Model[27].

Collateral: Service activity to a significant support person in an individual's life with the intent of improving or maintaining the mental health status of the person in care. The person in care may or may not be present for this service activity. Service activity to a significant support person or persons in an individual's life for the purpose of providing support to the person in care in achieving client plan goals. Collateral includes one or more of the following: consultation and/or training of the significant support person(s) to assist in better understanding of mental illness and its impact on the person in care; and family counseling with the significant support person(s) to improve the functioning of the person in care. The person in care may or may not be present for this service activity.

Rehabilitation: Service activity which includes assistance in improving, maintaining, or restoring an individual or group of individual's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. May be provided individually or in a group setting. See below for more information about this service type as it relates to Peer Support Specialists.

Intensive Home-Based Services (IHBS): Services are individualized, strength-based interventions designed to address behaviors and/or symptoms that interfere with a youth's functioning. Interventions are aimed at helping the youth build skills necessary for successful functioning in the home and community and improving the family's ability to help the youth successfully function in the home and community. Must be determined necessary by the CFT and documented in the CFT action plan.

Therapy: Service activity which is a therapeutic intervention that focuses primarily on symptom reduction as a means to improve functional impairments. Therapy may be delivered in an individual or group format and may include family therapy at which the person in care is present. Therapy may only be provided by LPHA staff or Psychiatrists/Psychiatric Nurse Practitioners.

Medication Support Services: Services provided by medical staff which include prescribing, administering, dispensing, and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the youth.

Crisis Intervention: Service, lasting less than 24 hours, to or on behalf of a youth for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral, and therapy. Note that billing for crisis intervention services is limited to 8 hours per instance.

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27   https://calswec.berkeley.edu/programs-and-services/child-welfare-service-training-program/core-practice-model

Treatment Team

SUD services are often provided through a team-based approach. While the precise composition of teams varies in each individual situation, it is not uncommon to have treatment teams with some combination of LPHAs, AOD Counselors, Peer Support Specialists, medical providers and others who work with the person in care. It is critical that treatment teams include the person in care and center their voice and priorities as the treatment team collaborates to support the person in care in meeting their goals. Teaming should be a seamless part of treatment and all members should work collaboratively to ensure that work is highly coordinated and aligned across providers. Doing this well takes intentional partnership, information-sharing, and focus. Treatment teams are highly encouraged to use consensus building decision making techniques and to solicit and explore viewpoints across the team.

CO-OCCURRING TREATMENT

A substantial number of people experience co-occurring mental health and substance use disorders. These conditions can be treated via "co-occurring treatment", with clinically appropriate services for mental health conditions in the presence of a co-occurring substance use disorder, covered in all delivery systems. Likewise, clinically appropriate services for substance disorders in the presence of a co-occurring mental health disorder are also covered in all delivery systems.

All services shall be delivered within the practitioner's scope of competence.

PROGRESS NOTES

In previous sections, we explored the use of the screening tools, assessment, diagnosis, and problem lists to best identify the person's care needs and treatment options. Now, we will explore the use of progress notes for documenting services as practitioners work with individuals to address their needs.

Progress notes have multiple functions. First and foremost, progress notes are used as a basis for planning care and treatment among practitioners and across programs. Progress notes are communication tools; therefore, each progress note should be understandable when read independent of other progress notes. This means, documentation should provide an accurate picture of the person's condition, treatment provided, and response to care at the time the service was provided.

Secondly, progress notes are considered a legal record describing treatment provided for reimbursement purposes. The progress note is used for verification of billed services for reimbursement. As such, there must be sufficient documentation of the intervention, what was provided to or with the person, to justify payment. See Appendix V for sample note narratives that provide sufficient documentation of the intervention.

Lastly, as noted earlier, progress notes are also used to communicate with other care providers. For these reasons, abbreviations should be avoided, unless universally recognized, to facilitate clear and accurate communication across providers and for when notes are used for legal or other reasons. Keep in mind that the person in care has legal privilege to their medical record and may review the medical record documentation. They should be able to recognize the treatment described; therefore, it is recommended that clinical or programmatic jargon be avoided.

The following list are characteristics of a progress note that supports quality documentation. Consider the following characteristics when documenting[28]:

- ☐ Clear
- ☐ Consistent
- ☐ Descriptive
- ☐ Reliable
- ☐ Accurate/Precise
- ☐ Timely

Required Progress Note Service Information

- ☐ The type of service rendered
- ☐ A narrative describing the service, including how the service addressed the person's behavioral health need (e.g., symptom, condition, diagnosis and/or risk factors).
- ☐ The date that the service was provided to the person in care.
- ☐ Duration of the service, including travel and documentation time.
- ☐ Location of the person in care at the time of receiving the service.
- ☐ A typed or legibly printed name, signature of the service provider and date of signature.
- ☐ ICD 10 code.[29]
- ☐ Current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code.
- ☐ Next steps including, but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate.

Group Progress Notes

The information above remains consistent for services provided in a group setting, with the following additional requirements:

- ☐ For groups facilitated by multiple practitioners, a single progress note signed by one of the practitioners shall be used to document the group service provided. Progress notes shall contain the information as noted above and modifications and additional information as noted below:
- ☐ Information about the specific involvement and specific amount of time of involvement of each practitioner in the group activity, including time spent traveling to/from the service and documenting the service.
- ☐ A list of group participant names shall be maintained. Please note, due to confidentiality standards, the full list of group participants must **not** be kept in any single participant's personal health records, instead the MHP or practitioner must maintain the full participant list outside of any participant's health records.

Progress Note Writing Tips

Learning to write progress notes is a skill that takes time for individuals who are new to billing Medi-Cal services. While MHP rules vary regarding specific note content expectations, in general the below tips can assist you in writing high quality progress notes.

- Focus on the interventions and what you did during the service as the provider
- Use active verbs to describe your interventions rather than passive verbs

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28   Hess, Pamela Carroll. Clinical Documentation Improvement: Principles and Practice. Chicago: AHIMA Press, 2017.

29   https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

- Highlight the themes and topics of a service rather than documenting a "play by play" of the service.

- Use simple, concise, and professional language with clear and specific examples.

- Avoid jargon or abbreviations to keep the notes person-friendly

- Check the problem list and add to it to reflect the topics of the sessions as needed.

- If multiple services of the **same service type** (e.g., individual rehabilitation) were provided to the same person on the same day, consider writing one note for a cumulative duration of time rather than separate notes.

- Be precise in your service minutes – rounding is not permitted

- Schedule time in your calendar to complete note writing each day and limit interruptions during those times

Progress Notes Timeliness

As noted above, each progress note should stand alone and be clear, complete, accurate, and free of jargon and local abbreviations. Documentation should be completed in a timely manner to support the practitioner's recall of the specifics of a service. Progress notes should never be completed in advance of a service. Below are timeliness expectations determined by DHCS:

- **Routine outpatient services:** Documentation should be completed within three business days. If a note is submitted outside of the three business days, it is good practice to document the reason the note is delayed. Late notes should not be withheld from the claiming process. Based on the program/facility type (e.g., STRTP DHCS regulations[30]), stricter note completion timelines may be required by state regulation.

- **Crisis services:** Documentation should be completed within 24 hours.

- **A daily note** is required for documentation of some residential services, day treatment, and other similar settings that use a daily rate for billing. In these programs, weekly summaries are no longer required.

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and abuse[31] within the service provision and claiming system. Disallowances in audits will occur when there is evidence of fraud, waste, or abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed in this manual are necessary steps to promote compliance.

Screening	Assessment	Problem List	Care Coordination	Treatment	Care Transitions	Discharge

CARE TRANSITIONS

Given the multiple healthcare delivery systems and resources that a person in care can be served in, there is a need for care coordination to successfully transition between providers and care settings. We should think about care as occurring across a continuum with an understanding that people's needs change over time. Given that individual needs can also

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30   https://www.dhcs.ca.gov/Documents/STRTP-Regulations-version-II.pdf

31   Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d). Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual.

be addressed concurrently by providers in different agencies or systems, coordination of care is a necessary element of your service provision. The goal of care coordination is to meet the person's needs though proactive and deliberate activities that include the person in care and to organize or coordinate with other service providers to facilitate the appropriate delivery of services across providers, treatment settings, and healthcare systems. It is likely that the coordination of services may include other treatment team members to help carry out activities, with each provider identifying what roles and activities they are taking on that support the person in care's overarching wellness.

As noted earlier in this manual, there are multiple service delivery systems that cover distinct Medi-Cal services, with some not covered under the DMC/DMC-ODS program or best provided by another delivery system. Although a person may receive care from more than one delivery system or provider, the practitioner or Care Coordinator must ensure this is done without duplication. To avoid duplication of care and to facilitate the transitions between healthcare systems, DHCS is developing child and adult transition of care tools. Let us explore these tools with an understanding that additional information will be provided by DHCS regarding the transition of care tools in the future.

Screening	Assessment	Problem List	Care Coordination	Treatment	Care Transitions	Discharge

DISCHARGE PLANNING

Mental health treatment should always commence with the understanding that recovery is possible. Appropriate treatment and supports benefit people with a wide variety of conditions; lessening disability and improving the ability to live full and fulfilling lives. For this reason, the discussion about discharge planning begins at the time of initial assessment (as clinically appropriate) and continues throughout the course of treatment. Routinely asking yourself and the person in care how you will know when they are ready to discontinue treatment and what they imagine their life will look like after treatment is a valuable discussion that enhances engagement and instills hope for the future.

Discharge planning must include the person in care and their social supports as full partners in the planning process and should be done as far in advance as practical. Additionally, including other treatment providers, when applicable, paves the ways to successful transitions from one care setting to another. Detailed information on discharge planning should be clear, concise, and accurately communicated and documented.

A successful discharge discussion includes a review of how the person can continue to receive any necessary support and how those needs may be addressed post-discharge from the program. Information contained in discharge plans and shared with the person in care includes how the person's needs may be addressed, information on prescribed medications, the type of care the person is expected to receive and by whom, information on crisis supports, and available community services, to name a few. Additionally, providers who work with individuals ages 5 through 20 are required to complete the CANS at discharge and a PSC for individuals who are ages 4 through 17.

Claiming for Services

Code Sets for Claiming Services

In an earlier section we explored the importance of identifying needs, assessing for conditions and/or diagnoses to recommend medically necessary services and initiate care planning and treatment. Here, we will explore the intersection of progress notes with code sets for submitting claims for reimbursement. But first, let us talk about the different code sets and their uses.

- **DSM Diagnosis:** Captures clinical information about the person's behavioral health needs and other conditions (clusters of symptoms) based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). Treatment intervention is based on diagnosis, assessed need and problem list.

- **International Classification of Diseases - Clinical Modification (ICD-10-CM) Codes:** Captures detailed information about the disorder (granular information) and is used in claiming. The ICD is a standard transaction code set for diagnostic purposes under the Health Insurance Portability and Accountability Act (HIPAA).

- **Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Codes:** These codes are used to capture uniform information for billing medical services and procedure. County Behavioral Health currently uses primarily HCPCS codes to bill Medi-Cal. Starting in July 2023, a subset of services will be claimed using CPT codes. More information to follow.

These code sets are used throughout healthcare settings and offer standardization and uniformity for data collection, claims processing, and evaluation of disease prevalence and service provision. Now, let us take a brief look at the interplay of how interventions and code sets are used to claim for reimbursement of services.

Diagnosis and ICD-10 Codes

While a substance use diagnosis is *not* a prerequisite for access to covered services and a person may receive services prior to a final diagnosis, a diagnosis and corresponding ICD-10[32] code must be present on the claim for processing. Annually, the Centers for Medicare and Medicaid Services (CMS) publishes the approved lists of ICD codes to be used for Medicaid (Medi-Cal) reimbursement[33]. The CMS-approved ICD-10 code set includes options for use when services were rendered prior to establishing a diagnosis or when access criteria is met by means other than by diagnosis, such as due to trauma. In these instances, for example, the ICD-10 list includes codes for "other specified" and "unspecified disorders" or "factors influencing health status and contact with health services" (i.e., Z Codes). Each of these codes are allowable for Medi-Cal billing and can be used to claim for services.

Commonly Used Codes

Several elements are required for the successful submission of service claims for processing, including a diagnosis (preliminary, provisional or otherwise), a corresponding ICD-10 code, and either a CPT code or a HCPCS code. DHCS has issued guidance on the most commonly utilized codes.[34]

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32   32 BHIN 22-013 (ca.gov)

33   33 2022 ICD-10-CM | CMS

34   34 BHIN 22-013 (ca.gov)

CONCLUSION

We hope that this manual has given you useful tools to implement the service delivery system transformation and documentation redesign concepts foundational to CalAIM. Achieving the goals of CalAIM requires transformation across our system, including in the practice and documentation of services provided by Peer Support Specialists. Through coordination of care and strong engagement with the person in care, Peer Support Specialists can streamline documentation and provide higher- quality care and further the goals of improving access for all Californians.

APPENDICES

Appendix I: Acronym List

- **ACE**: Adverse Childhood Experience
- **BHIN**: Behavioral Health Information Notice
- **ASAM**: American Society of Addiction Medicine
- **BIPOC**: Black, Indigenous and People of Color
- **CalAIM**: California Advancing and Innovating Medi-Cal
- **CANS:** Child and Adolescent Needs and Strengths
- **CMS:** Centers for Medicare & Medicaid Services
- **CPT:** Current Procedural Terminology
- **DHCS:** Department of Health Care Services
- **DMC:** Drug Medi-Cal
- **DMC-ODS:** Drug Medi-Cal Organized Delivery System
- **DSM-5:** Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
- **EPSDT:** Early Periodic Screening, Diagnosis and Treatment
- **FFS:** Fee-for-Service
- **HCPCS:** Healthcare Common Procedure Code System
- **HIPAA:** Health Insurance Portability and Accountability Act
- **ICD-10:** International Classification of Diseases, Tenth Revision
- **LGBTQ+:** Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and others
- **LOC:** Level of Care
- **LPHA:** Licensed Practitioner of the Healing Arts
- **MAT:** Medication for Addiction Treatment
- **MCO:** Managed Care Organization
- **MCP:** Managed Care Plan
- **MHP:** Mental Health Plan
- **NSMHS**: Non-specialty mental health services
- **NTP**: Narcotic Treatment Program
- **PSC-35:** Pediatric Symptom Checklist
- **SMHS:** Specialty Mental Health Services
- **SUD:** Substance Use Disorder
- **TCM:** Targeted Case Management

Appendix II: Medi-Cal Plans by Type

Medi-Cal Benefits			
System	**Operated by**	**Services**	**Service Definition**
Mental Health Plan (MHP)	County Behavioral Health Departments	Specialty Mental Health Services (SMHS) – Carved out of overall Medi-Cal benefit within 1915b Waiver[35]	SMHS includes the following[36]: • Inpatient psychiatric services • Outpatient services, including intensive and community-based services, such as individual, family and group therapy, collateral, plan development and assessment. • Rehabilitative skill building services in individual and/or group settings • Targeted Case Management • Medication Support Services • Day Treatment Intensive or Rehabilitation • Crisis Intervention and Stabilization • Adult and Crisis Residential Treatment • Psychiatric health facilities • Population specific services such as Intensive Care Coordination, Therapeutic Foster Care, Intensive • Home-Based Services and Therapeutic Behavioral Services
Managed Care Plan (MCP)	Private insurance companies contracted with Department of Health Care Services[37]	Non-Specialty Mental Health Services (NSMHS) and Physical Healthcare	NSMHS include the following: • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies and supplements

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35 https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx

36 https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Boilerplate_2017-2022_MHP_Contract-Exhibits_A_B_ and_E.pdf

37 Managed Care Plans by county

Medi-Cal Benefits (cont.)			
System	**Operated by**	**Services**	**Service Definition**
Fee For Service (FFS) Providers	Department of Health Care Services	Non-Specialty Mental Health Services (NSMHS) and Physical Healthcare	Same as available through MCP, however typically through private practitioners or clinics.
County Drug Medi-Cal Organized Delivery System (DMC-ODS)	County Behavioral Health Departments	ASAM Level of Care Substance Use Treatment	Continuum of Care modeled after the American Society of Addiction Medicine (ASAM) criteria[38] including: • Outpatient • Intensive Outpatient • Partial Hospitalization • Residential Treatment (low and high intensity) • Inpatient (Medically Monitored or Medically Managed) • Opioid Treatment Program (OTP) and other Medication for Addiction Treatment (MAT)
Drug Medi-Cal (DMC)	State Department of Health Care Services (DHCS)	Substance Use Treatment	Includes the following[39]: • Narcotic Treatment Programs • Outpatient drug free treatment, including medication services, treatment planning, crisis intervention, collateral, individual counseling, and group counseling. • Day Habilitative services • Perinatal residential • Naltrexone treatment

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38   ASAM LOC Criteria

39   https://govt.westlaw.com/calregs/Document/I12C91B008DA411E4A0F094BBA3CAFB62?transitionType=Default&context-Data=%28sc.Default%29

Appendix III: Scope of Practice Matrix

	Physician	Licensed or Waivered Psychologist (post doctorate)	Licensed, Registered or Waivered staff: ACSW/LCSW, AMFT/LMFT, APCC/LPCC (post MA/MS)	RN with Master's degree in MH Nursing or related field	Psychiatric Nurse Practitioner	Registered Nurse	Licensed Vocation Nurse/Licensed Psychiatric Technician	Trainee/Student/Intern: Post BA/BS degree. Enrolled in MA/MS/doctorate program	Mental Health Rehabilitation Specialist: BA/BS in MH related field and 4 yrs MH experience	Certified Peer Specialist	Other Qualified Staff approved by BH Director: typically 18+, High School Equivalency, Driver's License
Assessment: MH + medical history (hx), Substance use + exposure, strengths, risks, barriers to achieving goals	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Assessment: Diagnosis, MSE, medication hx, assessment of relevant conditions and psychosocial factors affecting the person's physical and MH	Yes	Yes	Yes	Yes	Yes	No	No	Yes*	No	No	No
Behavioral Health Prevention Education Service	No	No	No	No	No	No	No	No	No	Yes*	No
Collateral	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Care/Client/Treatment Plan	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes++	Yes++	Yes*,++	Yes++	No	Yes*,++
Intensive Care Coordination (ICC)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Intensive Home-Based Services (IHBS)	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Medication Support	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Medication Prescribing	Yes	No	No	No	Yes	No	No	No	No	No	No
Medication Administering	Yes	No	No	Yes	Yes	Yes	Yes	No	No	No	No
Medication Dispensing	Yes	No	No	Yes+	Yes	Yes+	No	No	No	No	No
Plan Development	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Problem List	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes*	Yes*
Psychological Testing	No	Yes	No	No	No	No	No	Yes+++	No	No	No
Psychotherapy	Yes	Yes	Yes	No	Yes	No	No	Yes*	No	No	No
Rehabilitation Counseling	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Self Help/Peer Services	No	No	No	No	No	No	No	No	No	Yes*	No
Targeted Case Management	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*
Therapeutic Behavioral Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	No	Yes*

* Under the direct supervision of an LPHA/LMHP
+ Training and certification requirement may apply
++ May require close supervision if issues of danger to self or others are present
+++ Typically limited to post-master's doctorate students

Appendix IV: DHCS Priority SDOH Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Appendix V: Sample Progress Note Narratives

Engagement

Peer Support Specialist contacted the client via telephone to introduce myself and support the person in engaging in care. Discussed information on what to expect during the upcoming session. Answers questions and clarified expectations. Peer Support Specialist shared their role in supporting the person through the process. This staff collaborate with treatment team members and provide pertinent information for upcoming session. Client reported appreciation for the information, including feeling less stressed out about the upcoming session. Client was able to identify the plan for the upcoming session, include the date/time and transportation.

Developing Recovery Goals

I collaborated with client to review his problem list. I prompted client to share his life goal and brainstormed how it would be incorporated into his problem list. I reviewed the needs and strengths identified during the assessment by the clinician and worked with client to determine how to leverage his strengths to support his areas of need. Client was engaged throughout the session, though he struggled to identify strengths. Client agreed with the problem list developed. This Peer Support Specialist will continue individual therapeutic sessions, with the next session scheduled for later this week.

Skill Building

In effort to support wellness skills, I engaged her in an open-ended conversation about her day and how she has been feeling. I praised her for using I statements and ability to reflect on things that went well. I validated her responses and responded with empathy, encouraging her to express her feelings. I discussed and reviewed her current coping skills (ie, reading, listening to music, etc).1 normalized her need to take a break from difficult situations and reminded her to take time outside. Coached client through role play on using healthy ways to let others know that she needs to stay well and healthy. Client was verbal and engaged throughout the session. I will meet with client next week at the community wellness center to support her in the identification of a new class.

Resource Navigation

This staff provided the following intervention to address the client's inability to manage emotions due to their anxiety. This staff contacted Group Intervention Center and spoke with intake counselor (Susan) to obtain information about the appropriateness of their Healing Heart Program to meet client's needs.

Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Healing Hearts indicated client seemed appropriate for their program group and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend this support group.

Collaboration with Significant Supports

Client's father and grandmother report that on most days, client closes herself off in her bedroom as soon as she comes home on visits and only leaves her room to meet basic physical needs. These behaviors resulting from client's depression are creating challenges in family relationship, per father. This Peer Support Specialist provided empathic and validating statements, acknowledging caregiver's frustration and concern. Peer Support Specialist provided education on recovery principles and ways to support the client. Peer Support Specialist discussed common challenges amongst families when there are notable differences in the expression of respect between the generations within household. I solicited feedback from caregivers about their understanding of recovery and identified things they can do that may best support the client. Client's caregivers were forthcoming in expressing their challenges to understand how to best support client. They were receptive to information and expressed willingness to try new approaches with client. I will continue to work with client and the client's family in identifying new methods to respond to client's isolative behavior.

Appendix VI: Documentation Guide Change Log

Page No.	Change Description	Revision Date

Any questions & comments related to this manual can be submitted to:

info@calmhsa.org