CalAIM Clinical Assessment 7 Domains

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SMARTCARE TIPS
• To bill for the face to face assessment session(s) please document in a service note and use procedure code "Assessment -LPHA" to document and bill for your time with the client • In the narrative of the service note include who was present, review of informed consent and/or other documents, and provide a brief description that the CalAIM assessment was completed and refer to the document for the clinical information and treatment recommendations. • To complete the CalAIM Assessment (formerly comprehensive assessment): With your client selected search for "CalAIM Assessment" to open the assessment form. Complete each domain section with the clinical information and formulate a clinical summary and diagnosis. • Ensure you are saving your work regularly, any saved but not signed assessments will appear in the "Documents (client)" list screen. • When you are ready to finalize and submit, "Sign" the document • For more information: see SmartCare Knowledge base Clinical Documentation - 2023 CalMHSA

Descriptions of the 7 Domains

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.*

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*** *– summary 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*
- ***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.*