ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Behavioral Health Clinical Chart Audit

Instructions

October 1, 2025

CYE26

BHCCA Instruction Guide Draft 8-21-25

INTRODUCTION

The Behavioral Health Clinical Chart Audit (BHCCA) serves as a critical accountability mechanism to ensure that contracted behavioral health providers deliver care that is compliant, person-centered, and aligned with Arizona Health Care Cost Containment System (AHCCCS) standards. These audits advance the state's goals of safeguarding program integrity, promoting clinical quality, and supporting the effective use of public resources.

Developed collaboratively by AHCCCS, health plans, providers, and community stakeholders, the BHCCA is a dynamic and evolving framework aimed at improving oversight in behavioral health care. It employs standardized, data-driven evaluations to provide measurable insights into provider performance, reinforces regulatory compliance, and guarantees that care delivery adheres to principles of medical necessity, person-centered treatment, and evidence-based practice — crucial elements for effective member care.

The incorporation of audit tool elements and the creation of corresponding audit instructions are guided by relevant AHCCCS policies, as well as foundational frameworks and standards. These include but are not limited to the Arizona Department of Health Services' Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, the Arizona Vision's Twelve Guiding Principles for the Children's System of Care and federally endorsed evidence-based practices. Specific policy references are detailed in the tables below.

AHCCCS Medical Policy Manual (AMPM) AMPM Policies (Hyperlink)			
AMPM 300-2A	AHCCCS Covered Services	AMPM 570	Provider Case Management
AMPM 300-3	AHCCCS Integrated System of Care Structure, Values, and Principles	AMPM 580	Child and Family Team
AMPM 310-B	Title XIX XX1 Behavioral Health Services Benefit	AMPM 582	Support and Rehabilitation Services for Children, Youth, and Young Adults
AMPM 320-O	Behavioral Health Assessments and Treatment Service Planning	AMPM 583	Family Involvement in the Children's Behavioral Health System
AMPM 320-P	Eligibility Determinations for Individuals with Serious Emotional Disturbance and Serious Mental Illness	AMPM 584	Youth Involvement in the Children's Behavioral Health System
AMPM 320-Q	General and Informed Consent	AMPM 587	Transition to Adulthood

AMPM 320-R	Special Assistance for Members with Serious Mental Illness	AMPM 590	Behavioral Health Crisis Services
AMPM 320-U	Pre-Petition Screening, Court Ordered Evaluation, and Court Ordered Treatment	AMPM 640	Advanced Directives
AMPM 510	Primary Care Providers (FYI only)	AMPM 910	Quality Management/Performance Improvement Program Scope
AMPM 520	Member Transitions	AMPM 940	Medical Records and Communication of Clinical Information
AMPM 541	Coordination of Care with Other Government Agencies	AMPM 1040	Outreach, Engagement and Re-Engagement for Behavioral Health
AMPM 550	Serious Emotional Disturbance Identification	AMPM 1700	Health Related Social Needs (H2O)

AHCCCS Contractor Operations Manual ACOM Policies (Hyperlink)	
ACOM 404	Contractor Website and Member Information
ACOM 405	Cultural Competency, Language Access Plan and Family-Member Centered Care
ACOM 414	Requirements for Service Authorization Decisions and Notices of Adverse Benefit Determination
ACOM 417	Appointment Availability, Transportation Timeliness, Monitoring, and Reporting
ACOM 449	Behavioral Health Services for Children in Department of Child Safety (DCS) Custody and Adopted Children

Jason K. Settlement Final Agreement
Jason K. Settlement Agreement 2001

Jacob's Law
A.R.S. § 8-512.01

Foster Care Litigation Revised Settlement Agreement
B.K. ex rel. Tinsley, et al. v. Faust, et al., CV-15-00185-PHX-ROS (August 14, 2020)

Interagency Service Agreement Arizona Health Care Cost Containment System and Arizona Department of Child Safety
YH22-0026 Contract Amendment DCS Supplemental Report

Arnold v. Sarn Stipulation
Arnold v. Sarn (January 8, 2014)

AHCCCS Contracts
Effective: October 1, 2025
AHCCCS Contract Amendments Hyperlink

Evidence-Based Practices
SAMHSA System of Care Guiding Principles Hyperlink

BEHAVIORAL HEALTH CLINICAL CHART AUDIT (BHCCA) FOUNDATIONS AND RATIONALES

As MCO health plan auditors, your work is essential to ensuring that behavioral health providers deliver care that is not only compliant with policy but also effective, person-centered, and recovery-oriented. Auditing clinical records is not merely a technical task, it is a vital opportunity to evaluate how well documentation reflects meaningful, coordinated care that addresses the complex needs of members experiencing mental health and substance use challenges.

Effective Member Care involves the timely delivery of behavioral health services that are evidence-based, person- and family-centered, culturally responsive, and integrated across systems. It promotes recovery, resilience, and measurable improvements in a member's health, functioning, and quality of life.

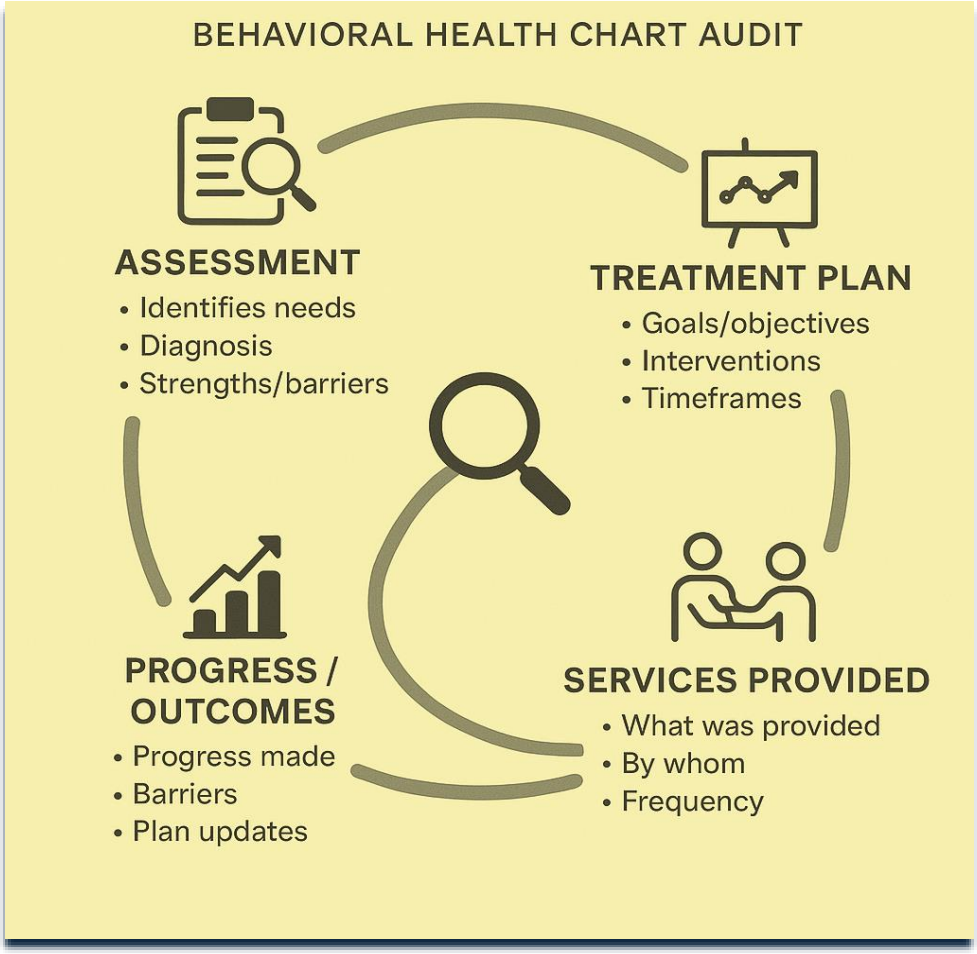
Key characteristics of high-quality behavioral health care are:

- **Evidence-Based**: Aligned with clinical research, guidelines, and proven practices.
- **Person- and Family-Centered:** Tailored to the members' needs, goals, and values, with involvement from families and natural supports.
- **Strengths-Based and Recovery-Oriented:** Focused on capabilities, hope, and growth—even when progress is non-linear.
- **Culturally Competent and Responsive:** Delivered with respect for each member's background and lived experience.
- **Timely and Accessible:** Provided promptly and without unnecessary barriers.
- **Coordinated and Integrated:** Connected across behavioral, physical, and social systems (e.g., housing, education, justice).
- **Outcome-Focused:** Measured by improvements in stability, independence, and wellness, as defined by the member.

This guide is designed to support your audit activities by providing a structured, standardized framework for evaluating whether provider documentation demonstrates effective, clinically justified,

and person-centered care. Your findings help ensure accountability and drive improvements in the behavioral health system's ability to serve those who rely on it most.

THE GOLDEN THREAD



A key principle in this evaluation is the concept of the ***Golden Thread***, which is a term used to describe the essential alignment that should be evident throughout the clinical record. Effective documentation is not simply a collection of forms or isolated notes; it should reflect a coherent narrative in which the member's identified needs, goals, services, and outcomes are logically and clinically connected.

In your capacity as stewards of clinical quality, your role is crucial in ensuring that behavioral health services meet standards for medical necessity, clinical appropriateness, and regulatory compliance. The "Golden Thread" concept is central to this evaluation, representing the clear and logical connections that should be evident throughout all elements of a member's clinical documentation.

The graphic above illustrates this principle, outlining four core components that must align to demonstrate that care is purposeful, person-centered, and clinically justified. Each aspect of the ***Golden Thread*** is further described below:

1. Assessment

   Documentation must clearly establish the members' clinical needs, functional impairments, diagnoses, and relevant psychosocial factors. This information serves as the foundation for determining medical necessity and it guides all subsequent care planning.

2. Service Plan

   The service plan must reflect the members' expressed goals, preferences, and priorities to ensure a person-centered approach. Goals and objectives should be individualized, measurable, and directly informed by the assessment. Interventions must not only address identified clinical needs but also align with the member's aspirations and desired outcomes. Including the member's voice in the narrative portion ensures that care planning is collaborative, respectful, and aligned with what matters most to the member.

3. Services Provided

   All services must align with the service plan in terms of scope, intensity, and frequency. This alignment ensures services are not only clinically appropriate, but also responsive to the member's stated goals and preferences. Service delivery should reflect a consistent commitment to supporting the member in achieving their identified outcomes, reinforcing both medical necessity and personal relevance in care.

4. Progress / Outcomes

   Progress notes should reflect the members' response to treatment, provide evidence of progress or lack of progress, and note any modifications made to the treatment plan.

The ***Golden Thread*** connects these elements, ensuring continuity and clinical relevance throughout the member's care. Breaks in this thread, such as services that fail to address identified needs or progress notes that do not align with treatment goals, may indicate problems with care quality, misaligned services, or documentation irregularities. These issues can undermine the effectiveness of the treatment and compromise compliance with established standards.

In Summary:

As an MCO health plan auditor, you are uniquely positioned to assess whether the member's behavioral health care is not only compliant with regulatory standards, but also meaningful, person-centered, and recovery oriented. The ***Golden Thread*** serves as your guide in evaluating whether clinical documentation consistently reflects the member's needs, goals, services, and outcomes. Strong alignment indicates intentional, high-quality care; gaps may reveal opportunities for improvement.

Use this instruction guide to apply a standardized, evidence-informed approach to your audit reviews. Your findings will directly support accountability, highlight areas for provider growth, and help strengthen the behavioral health system's ability to deliver effective care to those who need it most.

AUDIT TOOL STRUCTURE AND PURPOSE

General Information

The Arizona Health Care Cost Containment System (AHCCCS) promotes a model of behavioral health care that is strength-based, person- and family-centered, culturally and linguistically appropriate, clinically sound, and delivered in the least restrictive environment. Services must be timely,

individualized, and guided by best practices that emphasize engagement, collaboration, and effective supervision.

This model is grounded in three equally important components:

- Input from the member and family/significant others, reflecting their unique strengths, needs, preferences, and goals,
- Input from other key individuals or systems involved in the member's life and care, and
- Clinical expertise, including evidence-based practices and sound clinical judgment.

The Behavioral Health Clinical Chart Audit is one of several quality assurance tools used to evaluate adherence to this model. The BHCCA assesses whether documentation in the clinical record demonstrates person-centered, medically necessary, and outcome-focused care in accordance with AHCCCS policy and standards.

This instruction manual is intended to provide a comprehensive framework for conducting clinical chart reviews using the AHCCCS Behavioral Health Clinical Chart Audit Tool. It establishes a **s**tandardized approach to evaluating key aspects of behavioral health service delivery, including:

- Quality and completeness of assessments,
- Alignment and continuity of service planning,
- Incorporation of the member's and family's voice and choice throughout treatment,
- Coordination of care across systems and providers, and
- Implementation of effective, recovery-oriented services.

The BHCCA audit process is designed to meet requirements outlined in:

- Arizona Administrative Code (A.A.C.) R9-10-1011 and R9-21-301,
- AHCCCS Medical Policy Manual (AMPM), and
- AHCCCS Contractual Requirements.

Only the standards and instructions outlined within contract, policy, manual, or the BHCCA Findings and Summary Report are to be used when scoring audit elements. Use of any other criteria or interpretation is not permitted.

The Behavioral Health Clinical Chart Audit Section Summary

Section I: Evaluation of any member assessment conducted during audit period. The Assessment is defined in contract as, "An analysis of a patient's needs for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient." The Behavioral Health Clinical Chart Audit tool will assess the presence, timeliness, and relevance of the assessment in identifying the members' needs and informing subsequent care.

Section II: Evaluation of the members' service plan(s) that were active during the audit period. The Service Plan is defined in contract as, "A complete written description of all covered health services and other informal supports, which includes individualized goals, peer and recovery support and family support services, care coordination activities and strategies to assist the member in achieving an

improved quality of life." The Behavioral Health Clinical Chart Audit tool is used to ensure that the service plan reflects needs identified within the assessment.

Section III: Evaluation of the clinical chart. The General Clinical Chart section is designed to focus on evidence that demonstrates the member is achieving personal and recovery goals. This section is also meant to identify the effectiveness of behavioral health services surrounding those needs identified within the assessment and related service plan updates. Items included within the general clinical chart may include but are not limited to: (a) progress notes, Child/Family Team (CFT) or Adult Recovery Team (ART) documentation, (c) Transition Age Youth (TAY) activities, (d) CALOCUS or other assessment documents, I High Needs Case Manager involvement, and/or (f) other screening tools utilized based on clinical need.

Section IV: Evaluation of the providers' attention to the members' unique needs, preferences, and values. Person-centered planning emphasizes shared decision-making, respect for individual autonomy, and the active involvement of the member, or when applicable, the child, family, or Health Care Decision Maker (HCDM) in the development and coordination of care. This section emphasizes the importance of delivering behavioral health care that is not only clinically appropriate but also meaningful, respectful, and responsive to the member as a whole person. The Behavioral Health Clinical Chart Audit tool will assess whether documentation reflects a collaborative planning process that incorporates the member's voice, prioritizes individualized goals and strengths, and integrates the member's cultural identity, beliefs, and traditions into treatment planning and service delivery.

Section V: Evaluation of the providers' attention to the specific requirements for children in the custody of DCS. The DCS CHP section is designed to include specific elements for utilization by DCS CHP to ensure compliance with B.K. ex rel. Tinsley, et al. v. Faust, et al., CV-15-00185-PHX-ROS (August 14, 2020).

Sampling Methodology

To maintain the integrity and consistency of clinical chart reviews, contractors must adhere to a standardized sampling methodology. This approach is designed to produce statistically valid and representative audit results that accurately reflect the entire scope of the health plan's covered population. It takes into account various lines of business (LOBs), geographic service areas (GSAs), and member characteristics. This methodology ensures that the selected charts provide valuable insights into the provider's service delivery and compliance with care coordination standards.

Providers subject to the BHCCA: Contractors shall ensure that all network providers classified as Provider Type 77 (Behavioral Health Outpatient Clinic) or AHCCCS Provider Type I/C (Integrated Clinic) who are designated as Health Homes or serve as Primary Behavioral Health Providers in the capacity of a Health Home are included in the BHCCA provider list. These providers are subject to the audit requirements in the Behavioral Health Clinical Chart Audit (BHCCA) Instruction Guide. All Health Home providers shall be subject to the BHCCA **at least once annually**.

If the Contractor identifies a provider that qualifies as Provider Type 77 or I/C but is not designated as a Health Home or serving in the functional capacity of a Health Home or Primary Behavioral Health Provider, the Contractor may exclude these providers from the BHCCA audit list. In these cases, the Contractor must ensure that these providers are audited according to the applicable requirements outlined in the AHCCCS Medical Policy Manual (AMPM) Policies 910.

To support identification of eligible providers and validate service delivery, Contractors may reference behavioral health and integrated service codes commonly associated with Health Home functions. These codes should be used solely to support validation of the provider's role and service activity and are not intended as stand-alone criteria for audit inclusion. These may include, but are not limited to:

- Behavioral Health Assessment (e.g., 90791, H0031)
- Case Management (e.g., T1016, T1016-U1 for CFTs)
- Therapy Services (e.g., 90832–90838, H0004)
- Psychiatric and Evaluation Visits (e.g., 90792, 99211–99215)

Sampling Requirements:

Contractors are required to use a stratified random sampling approach and must follow these parameters when selecting member charts for review:

- **Sample Size:** Select 30 charts per provider for review.
- **Eligibility Criteria:** Include only members who:
  - Have been assigned to the provider as their Health Home or acting as the member's health home or primary behavioral health provider,
  - The provider has actively delivered behavioral health and/or integrated care services to members for whom they are assigned or serving in the role of a Health Home,
  - Have been receiving services from that provider for at least 90 days.
- **Statistical Representation:** Samples must be:
  - Statistically representative of the health plan's overall member population.
  - Inclusive of all applicable Lines of Business (LOBs) and Geographic Service Areas (GSAs).
- **Sampling Method:** Implement a stratified random sampling method to ensure balanced representation across different populations and services. Health plans must ensure that the sampled population includes both adults and children, as applicable based on provider's contractual responsibilities.
- **Multiple Contracts:** If a Contractor manages multiple LOBs, the sample must reflect a representative population for each LOB. Providers and associated member charts should be selected accordingly, to ensure proportional representation across all contracted LOBs.

Providers with Small Sample Size: If a provider has fewer than 30 charts, include all available charts for that provider in the audit.

- **Adjustment of the Provider Sample:** The final list of providers to be audited must be adjusted as needed to achieve a minimum statistical significance, based on the contractor–provider relationship and the scope of review. Health plans are responsible for ensuring that the group of providers selected for audit is sufficiently large and diverse to accurately represent the member population across all applicable service areas and LOBs.

Each provider should be assigned to only one health plan for audit purposes to prevent duplication and ensure clarity in oversight responsibilities.

H2O-Enrolled Members

Addition of H2O Enrolled Members as a Line of Business:

The Health and Housing Opportunities (H2O) program is considered a ***distinct line of business*** for audit purposes. Health plans must ensure that H2O-enrolled members are included in the audit sample, when the MCO is actively serving this population.

Additional information regarding H2O requirements are listed in the H2O Appendix.

Eligible Population Criteria: Members must meet all of the following:

- Members with an SMI designation,
- Have Title XIX eligibility,
- Members who are Homeless or at-risk for homelessness,
- Diagnosed with a chronic health condition,
- H2O-enrolled members who received H2O-funded services during the audit review period.

Member Selection: To ensure accurate representation of H2O enrolled members in audit samples, Contractors shall utilize the information provided by AHCCCS in the Monthly Unique Eligible Population file. This shall be utilized to identify H2O-eligible members and program enrollment.

- If providers on the audit list are identified as H2O health homes, ensure that their H2O-enrolled members are part of the 30-chart sample (or fewer, if limited). If the provider serves only H2O members, those charts should comprise the full review sample.

DCS/CHP Additional Sampling Requirements: In addition to the general requirements above, audits for Department of Child Safety/Comprehensive Health Plan (DCS/CHP) providers must meet the following criteria:

- The audit sample must be large enough to achieve a 90% confidence level with a ± 10% margin of error.
- The sample must include charts representing the following subpopulations of children:
    1. Children with assigned high-needs case managers,
    2. Children without a high-needs case manager,
    3. Children who have been placed with multiple caregivers.

BHCCA LOB Matrix:

LOB	Population	Health Plan	Health Plan	Health Plan	Health Plan	Health Plan	Health Plan
ACC/RBHA	Adults only	Mercy Care	AzCH	---	---	---	---
ACC	Adults and Children	Mercy Care	AzCH	United Healthcare	Banner University	Molina	BCBS/Health Choice
ALTCS/DDD	Adults and Children	Mercy Care	---	United Healthcare	---	---	---
ALTCS/EPD	Adults and Children	Mercy Care	AzCH	United Healthcare	Banner University	---	---
DCS CHP	Children	Mercy Care	---	---	---	---	---
H2O	Adults SMI	Mercy Care	AzCH	United Healthcare	Banner University	---	---

Any requests for changes to the methodology must be sent via email to systemofcare@azahcccs.gov. Should changes to methodology be identified during the initial audit processes, the health plan shall submit notification of the necessary changes and rationale for those changes for review and approval.

Reporting Requirements: Contractors must submit a single, consolidated Behavioral Health Clinical Chart Audit (BHCCA) Findings and Summary Report that encompasses all awarded Lines of Business (LOBs) instead of separate reports for each LOB. The consolidated report must include delineated data, findings, and comparative analysis for multiple lines of business (when applicable) to ensure transparency, accountability, and compliance with all applicable audit and reporting requirements.

For detailed reporting requirements, please refer to the Behavioral Health Clinical Chart Audit Findings and Summary Report Requirements document available on the AHCCCS website (Clinical Chart Audit Findings & Summary Report - ISOC Page).

SECTION I: ASSESSMENT COMPONENTS, REQUIRED ELEMENTS AND GUIDELINES

This section evaluates whether the member's assessment meets contractual and policy requirements related to timeliness, content, and clinical relevance.

Purpose and Scope:

The assessment is intended to identify the member's current needs and to support reassessment as appropriate, either in response to significant life events, changing clinical circumstances, or within the required timeframes outlined in AHCCCS policy and contract. At minimum, assessments must be updated annually.

During reassessments, the provider must document whether there are any changes to the member's needs for each required assessment element. If no changes are identified, this must be clearly stated and supported in the documentation.

There is no requirement for a specific assessment form. However, the assessment must fulfill all applicable requirements as defined in AHCCCS policy and contract.

The assessment must be signed by a BHP. If the BHP signature is missing, the assessment is considered invalid and incomplete. In this case, none of the assessment elements (A-1 through A-8) may be scored Yes. ***Auditors will automatically score all assessment elements as "No" if the required BHP signature is not present.***

Acceptable Assessment Sources:

In addition to the primary assessment document, supporting information may be drawn from:

- Psychiatric or psychological evaluations,
- Standardized assessment tools (e.g., for depression, anxiety, trauma, or health-related social needs),
- Screenings or evaluations completed by other providers contributing to the member's care
- Documentation found in other sections of the clinical chart, including:
  - General Clinical Chart
  - Child and Family Team (CFT) or Adult Recovery Team (ART) notes
  - Case management notes

These supplemental sources may be used to validate specific assessment elements if they meet the scoring criteria.

ASSESSMENT REQUIREMENTS/GUIDELINES AND SCORING:

Assessment (A-1): Assessment Completion

Requirements/Guidelines: There is evidence that the member has had an assessment conducted within the last twelve months, which is included within the clinical chart. (AMPM 320-O)

This element is not specific to an initial or comprehensive assessment or reassessment. It is intended to validate the presence of an assessment having been completed with the member within the last 12 months. If there is not an assessment within the clinical chart that was completed within the 12-month timeframe, it shall not render the current/most recent assessment as invalid.

Clarifying Guidance:

- Confirm that if the assessment was completed by another provider within the last 12 months, that it was accepted only if the current provider reviewed and updated it within 48 hours of assuming care. Confirmation of review and acceptance shall be clearly documented.
- Missing, outdated, and unsigned assessments cannot be scored YES.

Scoring Instructions: To be scored YES, ALL of the following MUST be met.

☐ Assessment is present in chart (initial, comprehensive, or equivalent evaluation),

☐ The assessment was completed within the last 12 months,

☐ Signed by a Behavioral Health Professional (BHP).

Assessment (A-2): Behavioral Health Professional (BHP) Signature

Requirements/Guidelines: There is evidence that the assessment is signed by BHP or completed by BHT/BHPP and cosigned by BHP. (AMPM 320-O)

The intent of this audit element is to ensure that the assessment has been reviewed and validated by a qualified BHP. A BHP signature is required to confirm clinical oversight and appropriateness of the assessment findings and recommendations.

Clarifying Guidance:

- If the assessment was completed by a Behavioral Health Technician (BHT) or Behavioral Health Paraprofessional (BHPP), it must be reviewed and signed by a BHP within 72 hours of completion of the assessment, **OR** within 48 hours of assuming care if using a prior provider's assessment,
- If a BHP signature is NOT present, regardless of whether the 72-hour timeframe has passed, all assessment related elements *must be scored NO*, and the assessment shall be considered incomplete for the purposes of the audit.

Scoring Instructions: To be scored YES, the following MUST be met:

☐ The assessment was reviewed and signed by a BHP within 72 hours of the assessment completion date OR within 48 hours of assuming care if using a prior provider's assessment.

Assessment (A-3): Presenting Concerns & Diagnostic Evaluation

Requirements/Guidelines: There is evidence within the assessment of the member's presenting concerns, mental status exam, and diagnostic impressions. (AMPM 320-O)

This element ensures the assessment includes three essential components:

1. **Presenting concerns** that reflect the immediate reasons the member and/or their family are seeking behavioral health services. This information should help inform service and discharge planning,
2. A **Mental Status Exam (MSE)** that summarizes the assessor's observations of the member's appearance, behavior, mood, speech, thought processes, and overall functioning during the assessment. The MSE may appear as a standalone section or be integrated into the clinical formulation,
3. A **diagnostic impression** that applies DSM criteria and is supported by the member's symptoms, history, and relevant medical or psychosocial factors. A provisional diagnosis is acceptable when clinically appropriate.

Clarifying Guidance:

- If no diagnosis is given, the assessment must clearly document why (e.g., assessment incomplete, insufficient information, referral for further evaluation),
- A missing or vague MSE (e.g., single-word descriptions or copied templates) is not sufficient and should be scored **NO**,
- Diagnostic impressions should reflect a thoughtful synthesis of assessment findings, not just a diagnosis code without supporting context,

- All three components must be clearly documented and clinically relevant to support meaningful treatment planning.

Scoring Instructions: To be scored YES, ALL of the following MUST be met:

- ☐ Presenting concerns are clearly documented and reflect the member's or family's reason for seeking behavioral health services,
- ☐ A Mental Status Exam (MSE) is included, describing the member's appearance, behavior, mood, thought process, and functioning at the time of assessment,
- ☐ A diagnostic impression is present and supported by assessment findings, including symptoms, history, and relevant medical or psychosocial factors.

Assessment (A-4): Communication Accommodations

Requirements/Guidelines: There is evidence that the assessment included the member's needs for communication assistance have been evaluated, including any required accommodations for hearing, vision, cognitive limitations, or language interpretation. (ACOM 405)

This element verifies that the assessment evaluates whether the member requires communication accommodations to effectively participate in care. Reviewers should confirm that the assessor identified any barriers—such as cognitive limitations, language needs, medical or psychiatric conditions, or legal guardianship—that may impair the member's ability to express preferences, engage in planning, or access rights (e.g., grievances or appeals). If such conditions are present, the assessment should document any accommodations provided or note that none are needed.

Scoring Instructions: To be scored YES, the following MUST be met:

- ☐ The member's need for communication accommodations was evaluated, including consideration of hearing, vision, language, or cognitive limitations, **OR**
- ☐ If a communication barrier was identified (e.g., language need, cognitive impairment, psychiatric condition, or the involvement of a legal guardian who makes decisions), the assessment documents how it may impact the member's ability to engage in care, express preferences, or participate in planning or grievance processes, **AND**
- ☐ Any required accommodation or supports (e.g., interpreter, assistive devices, guardian involvement) are clearly documented, or the assessment states that no accommodations are needed.

Assessment (A-5): Health History & Risk Factors

Requirements/Guidelines: There is evidence within the assessment reflecting physical and behavioral health history, medication history, family and developmental background, trauma history, and risk factors, including exploitation, substance use, and safety concerns. (AMPM 320-O; AMPM 1021)

This element verifies that the assessor gathered a comprehensive history across multiple domains to inform clinical understanding and service planning. The assessment must reflect current and past physical and behavioral health history, medication use (including over the counter and natural remedies), family and developmental background, trauma history, and key risk factors such as substance use, exploitation, and safety concerns.

Auditors should confirm that:

- Health and medication history are documented or updated, including efforts to obtain external records,
- Family and developmental history are explored, updated, or documented as unchanged or unknown,
- Trauma and substance use histories are assessed or deemed clinically inappropriate to explore at the time, with rationale provided,
- The assessment addresses risk factors related to safety in the community, potential exploitation, and immediate intervention needs.

Information may be sourced from the current assessment or other parts of the clinical record, as long as the assessor references, updates, or builds upon prior documentation. Credit may be given when prior histories are reviewed and noted as unchanged.

Clarifying Guidance:

- Historical information may be drawn from prior assessments if the assessor documents that there were no changes since the previous assessment,
- If certain areas (e.g., trauma or family history) are clinically inappropriate to assess at the time, documentation must clearly state this and explain why,
- Supplemental data may be located in other parts of the chart (e.g., CFT/ART notes, case management documentation) but must be clearly linked to the current assessment,
- All items must be clearly addressed in the assessment or through supporting documentation in the clinical chart. If any checkbox is not met, the element may NOT be scored as a yes.

Scoring Instructions: To be scored YES, ALL the following boxes MUST be checked:

Health & Medication History

☐ Current and past physical and behavioral health history are documented,

☐ Medication history is included (or noted as not applicable), including prescriptions, OTC meds, and supplements,

☐ If external records are pending, the assessment includes documented efforts to obtain them.

Family & Developmental History

☐ Family history (e.g., medical, psychiatric, genetic) is documented or noted as unknown/unavailable,

☐ Developmental history (including birth/prenatal) is documented or confirmed as unchanged from a prior assessment,

Trauma History

☐ Trauma history (e.g., abuse, neglect, violence) is documented, or a clinical rationale is provided for why trauma screening was not appropriate at the time.

Substance Use History

☐ Substance use or exposure is assessed, or documentation indicates no concerns identified,

☐ A standardized tool (e.g., CRAFFT, ASAM) was used or equivalent questions are documented.

Exploitation & Safety Concerns

☐ Screening for exploitation (e.g., sexual, financial, medical) is completed or ruled out,

☐ A risk assessment addresses community impulsivity, safety, suicidality, self-harm, and access to means.

Assessment (A-6): Social & Environmental Factors

Requirements/Guidelines: There is evidence within the assessment reflecting current and/or past social and environmental needs, including living situation, socialization, education, vocational training, employment, and access to public or private resources. (AMPM 320-O; AMPM 1700)

This element evaluates whether the assessment captures key social and environmental factors that influence the member's functioning, access to care, and ability to achieve treatment goals. **The assessor must gather information related to:**

- Living environment and safety (e.g., housing, neighborhood, transportation, access to food, weapons, or other safety risks) Social supports (e.g., relationships, community connections, or documented isolation),
- Educational and vocational engagement (including current needs, goals, strengths, or barriers)
- Employment status and functioning (e.g., interest in work, supports needed, or impact on well-being),
- Access to public and private resources (e.g., food assistance, transportation, faith-based support, referrals to community services),
- Optional screening tools (*via hyperlinks below*) may include but are not limited to use of,
  - *PRAPARE* (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences), **OR**
  - *AHC-HRSN* (Health-Related Social Needs Screening Tool).

Documentation should reflect the member's current circumstances, relevant history, or indicate when a domain is not applicable. Reviewers should confirm that the information is sufficient to inform person-centered service planning and address potential social determinants of health.

Clarifying Guidance:

- If a particular domain (e.g., education or employment) is not applicable due to the member's age or circumstances, documentation must state this explicitly,
- If the assessment references prior documentation (e.g., "no change in housing" **OR** "employment history unchanged"), this is acceptable if clearly stated and current,
- Screenings or tools (e.g., PRAPARE) may be used to gather information but are not required if equivalent information is documented,
- All items must be present in the assessment or clearly documented elsewhere in the clinical chart and referenced by the assessor. **If any checkbox is not met, score this element as NO.**

Scoring Instructions: To be scored YES, ALL of the following boxes MUST be checked:

Living Environment & Safety

☐ Assesses current living situation and environmental factors (e.g., housing stability, neighborhood safety, food availability, access to transportation),

☐ Identifies any safety concerns in the home or community, including access to weapons or other risks.

Social Supports

☐ Assesses social relationships and supports (e.g., friends, family, faith-based or community groups), or documents that the member has no social supports by choice or circumstance.

Education & Vocational Training

☐ Assesses current or past involvement in education and/or vocational training, including interests, goals, or needs in these areas,

☐ Identifies strengths or barriers related to pursuing or maintaining educational or training activities.

Employment

☐ Documents employment status, interest in work or volunteering, and/or barriers to employment,

☐ Includes assessment of how employment (or lack thereof) impacts the member's life and functioning.

Access to Community Resources

☐ Evaluates awareness of, access to, and/or use of public or private community resources (e.g., food stamps, transportation, housing supports, faith-based or cultural groups),

☐ Includes any referrals or linkages made to address identified unmet needs or clearly documents that the member has no current needs in this area.

Assessment (A-7): Legal & Decision-Making Factors

Requirements/Guidelines: There is evidence that the assessment determined the presence or absence of a HCDM, guardian, or conservator; and assessed current and/or past criminal justice involvement. (AMPM 320-Q; 320-R; AMPM 320-U; AMPM 580)

This element verifies whether the assessment identifies any legal or decision-making considerations that could impact care coordination or consent to treatment. These factors include the involvement of an HCDM, guardian, or conservator, as well as any involvement with the criminal justice system. Clear documentation of these factors helps ensure appropriate consent, risk assessment, and coordination of care with relevant legal systems. If there is no involvement in any of these areas, the assessment must explicitly state this.

Clarifying Guidance:

- If the member has no legal, court, or justice involvement, the assessment must clearly state this,
- For adults with limited capacity, the role of the HCDM must be clearly outlined and documented,
- For children in foster care or tribal custody, documentation must specify legal guardianship, and the entity authorized to consent for care.

- Credit may be given when historical information is referenced and updated with a "no changes" notation,
- For children, identifies whether DCS, Tribal Social Services, or another legal entity holds custody or authority.

Scoring Instructions: To score YES, ALL the following boxes MUST be checked:

- ☐ Assesses the presence or absence of an HCDM, guardian, or conservator,
- ☐ If an HCDM exists, there is documentation of their role in service planning and along with supporting legal documentation in the clinical chart,
- ☐ Assesses current or past criminal justice involvement (e.g., probation, parole, diversion, incarceration, victim/witness status).

Assessment (A-8): Court-Ordered Evaluation / Treatment (COE/COT)

Requirements/Guidelines: There is evidence that the assessor determined the presence of a court order or the need for a court ordered evaluation has been identified and the screening agency has been notified. (AMPM 320-U)

This element verifies whether the assessment evaluates the member's current court-ordered status or potential need for a Court-Ordered Evaluation (COE) or Court-Ordered Treatment (COT). This applies only to adult members (ages 18 and older).

Clarifying Guidance:

- The assessment determines whether a court order is currently in place,
- If a need for COE is identified (e.g., DTS/DTO/PAD/GAD), the screening agency is notified,
- If there is no current court order and no need for evaluation, this is explicitly documented,
- If the member is under 18, this element is scored N/A.

Scoring Instructions: To be scored YES, ONE of the following MUST be documented (*for adults only*):

- ☐ The assessment confirms the presence of a court order, and the provider has requested or obtained a copy, **OR**
- ☐ The assessment identifies a need for a COE, and the screening agency has been notified, **OR**
- ☐ The assessment clearly states that the member is not currently court ordered and does not meet criteria for referral,
- ☐ **Score N/A** – The member is under the age of 18 and COE/COT does not apply.

SECTION II: SERVICE PLAN – PURPOSE AND SCOPE

This section assesses whether the service plan effectively addresses the member's assessed needs, preferences,, and goals, in collaboration with the member, their family, and/or Health Care Decision Maker (HCDM). The plan must align with the member's vision of recovery, honor their voice and choices, and promote care in the least restrictive setting.

A well-developed service plan is informed by an understanding of what the member and their support system hope to achieve, how they define success, and what outcomes are most meaningful to them. It

is essential to integrate cultural identity, religious beliefs, family practices, and personal traditions respectfully throughout the planning process.

Service plans must:

- Be strengths-based and directly address the needs identified in the assessment,
- Align with the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems or the 12 Arizona Principles for Children's Behavioral Health, as appropriate,
- Reflect the member's desired outcomes through documentation,
- Be revisited throughout treatment. During subsequent reviews, such as reassessments, Child and Family Team (CFT) meetings, or Adult Recovery Team (ART) meetings, the plan must be updated to reflect progress, new priorities, or changes in the member's circumstances,
- For **individuals under court-ordered treatment,** the service plan must incorporate the requirements of the order while ensuring that the member's personal goals remain central to the care planning process.

Distinction Between a Service Plan and a Treatment Plan:

For audit purposes, it is crucial to understand that a Service Plan and a Treatment Plan serve different but complementary functions.

The Service Plan is a comprehensive document that coordinates all covered services, supports, and strategies across various providers and key life domains such as physical health, housing, meaningful activity, social relationships, and community integrations to help the member achieve an improved quality of life. The Service Plan reflects the collective input of the member, their family, any HCDM *(or Designated Representative, as defined in the DCS CHP contract definition for "Designated Representative")* and all service providers. This plan must be collaboratively created with the member and/or HCDM, updated at least annually, and revised whenever significant life events occur.

The Treatment Plan in contrast, is a focused, clinically specific plan created by an individual provider to address a diagnosed behavioral health condition. It identifies targeted interventions, measurable objectives, and therapeutic strategies based on the provider's current assessment. It is typically reviewed and updated more frequently to measure progress and adjust interventions.

In summary, think of the Service Plan as the comprehensive "master plan" integrating all aspects of the member's care, while the Treatment Plan serves as a targeted roadmap for addressing specific clinical needs. A member may have one Service Plan but can have multiple Treatment Plans from different providers, all of which should be integrated into and support the broader Service Plan goals. Both documents need to work together to ensure coordinated, person-centered care that addresses not just clinical symptoms but the member's overall well-being and life goals.

SERVICE PLAN REQUIREMENTS/GUIDELINES SCORING:

Service Plan (SP-1): Current Service Plan

Requirements/Guidelines: There is evidence in the medical record that the member has a current, clinically reviewed, and member-approved service plan. (AMPM 320-O)

The service plan must be current: The service plan was completed or updated within the past 12 months and remains active at the time of the audit. The plan should reflect the member's current needs, including alignment with the most recent assessment (***even if the assessment is out of date***).

Clinical Oversight: This verifies that the service plan was completed and includes the required signatures to demonstrate clinical oversight. A Behavioral Health Professional (BHP) must either complete and sign the plan directly or review and co-sign the plan if completed by a Behavioral Health Technician (BHT) or Behavioral Health Paraprofessional (BHPP).

Member participation: This verifies that the provider reviewed the service plan with the member and/or HCDM and obtained explicit consent indicating agreement with the goals and services documented. Consent may be verbal or written but must be documented in the clinical record.

Clarifying Guidance:

- Verify that the service plan is current.
- If completed by a BHT or BHPP, verify that a BHP also reviewed and signed the plan.
- If a BHP signature or member/HCDM agreement is NOT documented, all service plan-related elements must be scored NO, and the service plan shall be considered incomplete for the purposes of the audit.
- If the service plan is not current, or completed prior to the current, assessment auditors must score all service plan elements No.

Scoring Instructions: To score YES, ALL the following boxes MUST be checked:

- ☐ A service plan is present in the clinical chart,
- ☐ The service plan was completed or updated within the past 12 months,
- ☐ The service plan was completed and signed by a BHP **OR** it was completed by a BHT/BHPP, reviewed and signed by a BHP.
- ☐ Verbal or written consent indicating agreement was obtained from the member and/or HCDM and recorded**, OR**
- ☐ Written consent indicating agreement must be obtained and recorded for ALTCS E/PD members.

Service Plan (SP-2): Member and/or HCDM Engagement in Service Planning

Requirements/Guidelines: There is evidence in the medical record that the member and/or their HCDM actively participated in the development or review of the service plan. (AMPM 320-O)

This element evaluates whether the provider engaged the member and/or HCDM in a collaborative planning process that respects the member's voice, preferences, strengths, and recovery goals. Documentation should reflect more than just a signature; there should be clear evidence of meaningful engagement in goal setting and care planning.

Clarifying Guidance:

- The service plan should reflect the member's unique journey to recovery and include goals that are meaningful to them, not just provider assigned objectives

- **The presence of member/HCDM signature or consent is not sufficient without documentation of their active involvement in the planning or review process.**
- **Documentation may appear in progress notes, planning meetings, or on the service plan itself**.
- Score No if there is no evidence that the member/HCDM participated in the planning process.

Scoring Instructions: To be scored YES, ANY of the following boxes MUST be checked:

☐ The member and/or HCDM was engaged in developing, reviewing, or updating the service plan.

☐ There is documentation of the member's input or preferences being reflected in the service plan.

☐ A CFT or ART meeting occurred with the member and/or HCDM and involved discussion or revision of the service plan.

Service Plan (SP-3): Living Environment

Requirements/Guidelines: There is evidence that the service plan addresses needs identified and agreed upon within the assessment related to living environment/situation (e.g., safety/security, housing, neighborhood, food availability, transportation, safety/access to weapons or firearms, etc.). (AMPM 320-O)

This element verifies whether the service plan appropriately addresses the member's living environment needs, as identified in the assessment. These needs may include housing stability, neighborhood safety, access to food, transportation, and safety risks (e.g., access to weapons).

Clarifying Guidance:

- The assessment identifies any needs related to the living environment,
- The service plan addresses those needs, **OR**
- There is clear documentation that the member either:
  - Had no related needs, **OR**
  - Declined to include a goal,
- If a need was identified but not addressed, the record includes documented efforts by the provider to engage the member in discussing it.

Scoring Instructions: To be scored YES, ONE of the following MUST be documented:

☐ The service plan addresses identified needs related to the member's living environment, **OR**

☐ The assessment indicates no needs related to the living environment or the member declined to include a related goal, and this is clearly documented.

Service Plan (SP-4): Socialization

Requirements/Guidelines: There is evidence that the service plan addresses the needs identified within the assessment related to socialization (e.g., social supports, isolation, loneliness, recreational, and/or familial activities). (ACOM 320-O)

This element verifies whether the service plan addresses the member's socialization needs as identified in the assessment. This may include areas such as social support, isolation, loneliness, or participation in recreational or family-based activities.

Social connections play a critical role in recovery and well-being. If socialization concerns are identified in the assessment, they should be reflected in the service plan. If the member declines to include a related goal, documentation must show the provider's attempt to engage the member on this topic.

Auditors should confirm that:

- Socialization needs were assessed,
- The service plan addresses those needs, **OR**
- Documentation reflects that:
  - No needs were identified, **OR**
  - The member declined to include a related goal,
  - If a concern was identified but no goal was included, provider efforts to engage the member are documented.

Scoring Instructions: To be scored YES, ONE of the following MUST be documented:

☐ The service plan addresses identified needs related to socialization, **OR**

☐ The assessment indicates no socialization needs, or the member declined to include a related goal and this is clearly documented.

Service Plan (SP-5): Education and/or Vocational Training

Requirements/Guidelines: There is evidence that the service plan addresses the needs identified within the assessment related to education/vocation (e.g., education, vocational or other similar needs as identified by the member). (AMPM 320-O; AMPM 570)

This element verifies whether the service plan addresses education and/or vocational needs identified during the assessment. This may include goals related to school enrollment, GED completion, college preparation, vocational training, or career planning.

Auditors should confirm that:

- The assessment included a review of educational or vocational needs,
- The service plan includes a related goal when a need was identified,
- Documentation reflects that:
  - No needs were identified, **OR**
  - The member declined to include a related goal,
  - If a concern was identified but no goal was included, provider efforts to engage the member are documented.

Scoring Instructions: To be scored YES, ONE of the following MUST be documented:

☐ The service plan addresses identified needs related to education and/or vocational training, **OR**

☐ The assessment indicates no education or vocational needs, or the member indicated there were no education or vocational needs.

Service Plan (SP-6): Employment

Requirements/Guidelines: There is evidence that the service plan addresses the needs identified within the assessment related to employment (e.g., work preference, need for employment supports, volunteer activities, etc.). (AMPM 320-O; AMPM 570)

This element verifies whether the service plan addresses employment-related needs identified in the assessment. This may include work preferences, vocational goals, need for employment supports, volunteer interests, or barriers to obtaining or maintaining employment.

Auditors should confirm that:

- Employment-related needs were assessed,
- The service plan includes a related goal when a need was identified,
- If no employment needs were identified, or if the member declined to include a goal, this is clearly documented,
- If a need was identified but not addressed in the service plan, provider efforts to engage the member are documented,
- If the member is under age 16, this element may be marked **N/A.**

Scoring Instructions: Score YES, if either of the following is documented:

☐ The service plan addresses identified needs related to employment, **OR**

☐ The assessment indicates no employment related needs or the member declined to include a related goal, and this is clearly documented,

☐ **Score N/A** if the member is under age 16, and Employment planning is not applicable.

Service Plan (SP-7): Member/Family Vision

Requirements/Guidelines: There is evidence that the member/family vision is documented and that the service plan has goals that are based on the member/family vision. (AMPM Exhibit 300-3)

This element verifies that the member's and/or family's long-term vision is documented and that the service plan includes goals aligned with that vision. The vision should reflect the member's perspective on what recovery, or a meaningful life looks like, including how they will know when services are no longer needed.

Auditors should confirm that:

- A vision statement is present and reflects the member's/family's hopes, priorities, and values,
- Service plan goals are clearly based on or connected to this vision,
- If family or guardian participation is appropriate, documentation should reflect:
  - Their input in the planning process, **OR**
  - If unavailable, provider efforts to include them (e.g., outreach, coordination attempts).

Scoring Instructions: To be scored YES, ALL of the following MUST be checked:

☐ A member and/or family vision is present in the service plan or related documentation,

☐ Service plan goals align with the documented vision.

Service Plan (SP-8): Member/Family Strengths and Resources

Requirements/Guidelines: There is evidence that the service plan has goals that utilize the strengths and resources identified in the assessment and service planning process. (AMPM Ex 300-3; AMPM 320-O)

This element verifies that the goals outlined in the service plan build on the strengths of the member and/or family, as identified during the assessment and service planning process. Strengths may include:

- Internal qualities/strengths (e.g., motivation, resilience, problem-solving),
- Natural supports (e.g., family, friends, faith-based or community supports),
- External resources available to the member (government assistance for food, housing, etc.),
- Cultural values, traditions, and preferences.

Service plans should reflect strengths-based, flexible, and culturally responsive care. Goals should empower the member and support their autonomy by building on what is already working in their life.

Clarifying Guidance:

➢ If no clear strengths are used in goal development, or the connection is not documented, the element must be scored **NO**.

Scoring Instructions: To be scored YES, ALL of the following boxes MUST be checked:

☐ The goals of the service plan are based on the member's internal and external strengths identified in the assessment and service planning process,

☐ The service plan reflects a strengths-based, culturally responsive approach that supports recovery and promotes personal empowerment.

SECTION III: GENERAL CLINICAL CHART REQUIRED ELEMENTS AND GUIDELINES

The General Clinical Chart section is designed to assess whether the behavioral health services provided are effectively supporting the member's individualized goals, recovery, and overall well-being. This section evaluates the clinical documentation for evidence that:

- Services are aligned with the needs identified in the Assessment and Service Plan,
- Care is being delivered in a timely, coordinated, and person-centered manner, and
- The member is actively engaged in their care, with progress toward their identified goals being monitored and supported.

This section also serves to highlight system-level practices that demonstrate coordination, communication, and responsiveness to the member's evolving clinical and social needs. Reviewers will evaluate whether documentation reflects thoughtful service planning, collaborative delivery of care, and appropriate follow-through across the care continuum.

Examples of documentation that may be reviewed include, but are not limited to:

- Progress notes,
- Child and Family Team (CFT) or Adult Recovery Team (ART) meeting documentation,
- Transition Age Youth (TAY) planning activities,

- CALOCUS or other level-of-care tools,
- Involvement of a High Needs Case Manager when clinically indicated,
- Use of additional assessments or screening tools based on clinical need,
- Documentation of collaboration with primary care providers, social service agencies, and community resources.

In this section, a strong clinical record should reflect continuity of care, responsiveness to identified health-related social needs, coordination with natural and formal supports, and consistent engagement with the member and/or family to promote recovery and resilience.

GENERAL CLINICAL CHART REQUIREMENTS/GUIDELINES AND SCORING:

General Clinical Chart (GCC-1): Peer Support; Family Support

Requirements/Guidelines: There is evidence in the clinical chart that the member/family has been informed of and offered peer support or family support services, as appropriate based on age of member. (AMPM 320-O; AMPM 580)

This element evaluates whether the member and/or family was informed of and offered peer or family support services, as appropriate based on the member's age and clinical needs. Peer and family support are core components of person- and family-centered care and must be presented as available options during service delivery.

Auditors should confirm the following:

- The member/family received information about peer or family support services,
- A referral was made if services were requested,
- The member/family was offered provider choice, including internal and external options (e.g., through health homes, outpatient clinics, CSAs, or peer-run organizations).

Clarifying Guidance :

- If the member/family declined services, documentation of the offer is sufficient. If services were requested, documentation must reflect that a referral was made.

Scoring Instructions: To be scored YES, ALL of the following MUST be met:

- ☐ Documentation confirms that the member and/or family was informed of and offered peer or family support services,
- ☐ If peer/family support services were requested, documentation shows that a referral was made (internal or external).

General Clinical Chart (GCC-2): Service Plan Time Frames

Requirements/Guidelines: There is evidence in the clinical chart that services recommended in the service or treatment plan have been implemented as identified in the service or treatment plan, but not later than 45 days (21 days for DCS/CHP members). (AMPM 320-O; ACOM 417)

This element verifies whether services added to the service plan were initiated within required time frames:

- 45 calendar days,
- 21 calendar days for DCS/CHP members.

Auditors should look for clear documentation (e.g., progress notes, CFT/ART summaries, provider correspondence) showing that each newly planned service was started on time.

Clarifying Guidance:

- *Verify that the service plan is current,*
- A referral alone is not sufficient. Service Implementation must be confirmed by documentation of the actual service delivery,
- If no new services were added, documentation must reflect this,
- Even if it is a new service plan created within the last 45 days, the purpose of this element is to ensure member's needs are being identified and steps are being taken to implement new services. The item will still be scored as yes.

Scoring Instructions: To be scored YES, ALL of the following boxes MUST be :

☐ *The service plan is current (including the member/HCDM **and** BHP signature),*

☐ All new services added to the service plan were implemented within 45 days, or 21 days for DCS/CHP members,

☐ If no new services were added during the audit period, documentation confirms this (e.g., plan review with "no changes", member is stable, or similar notation),

☐ If a service was not implemented on time, documentation clearly explains the reason for the delay (e.g., member declined, scheduling issue, provider unavailable).

General Clinical Chart (GCC-3): Service Plan Implementation

Requirements/Guidelines: There is evidence in the clinical chart that services identified on the service plan were implemented as planned. (AMPM 320-O; AMPM 580)

There is evidence in the clinical chart that services identified on the current service plan were implemented. This element confirms that the member is actively receiving services listed in their service plan. Implementation must be documented through progress notes, provider communication, care coordination records, or other relevant clinical documentation. A referral alone is not sufficient unless accompanied by follow-up or evidence of the service being provided.

Clarifying Guidance:

- *The service plan is current,*
- Implementation may include direct service delivery, care coordination, or provider communication indicating initiation of the service,
- A service that has not yet occurred but is documented as pending (e.g., member on waitlist with active follow-up) may be accepted if the delay is clearly explained,
- If a member declines a service, documentation of their informed decision is acceptable,
- If no services have been implemented and no rationale is documented, this element must be scored NO.

Scoring Instructions: To be scored YES, ALL of the following MUST be met:

- ☐ *The service plan is current (including the member/HCDM **and** BHP signature),*
- ☐ Each service listed on the active service plan has documentation of implementation (e.g., progress notes, provider entries, coordination records),
- ☐ For services not implemented, there is documented rationale (e.g., member declined, provider unavailable, service pending with follow-up).

General Clinical Chart (GCC-4): CALOCUS Assessment

Requirements/Guidelines: There is evidence within the clinical chart that a CALOCUS assessment has been completed for members ages 6 through 17. (AMPM 320-O; AMPM 541; AMPM 570)

The CALOCUS (Child and Adolescent Level of Care Utilization System) is required for children receiving behavioral health services. It helps determine the appropriate level of care and informs service planning. **A CALOCUS must be completed as part of the initial assessment and every six months thereafter, or more frequently if there is a significant change in the member's status.**

The assessment may be completed by the rendering provider or documented through coordination with another provider involved in the member's care. Acceptable documentation includes a copy of the CALOCUS or its summary score and results.

Clarifying Guidance:

- ➢ A CALOCUS shall be completed for members **ages 6 through 17** receiving behavioral health services,
- ➢ Acceptable documentation includes a full CALOCUS tool or a summary of the level of care and score,
- ➢ If completed by another provider, there shall be documentation of review or collaboration,
- ➢ If no CALOCUS is present, assess whether one was due (e.g., initial intake or 6-month interval),
- ➢ Score **N/A** only if the member is **under 6** or **over 18**.

Scoring Instructions: To be scored YES, the following MUST be met:

- ☐ The CALOCUS has been completed for a child ranging from six years to 18 years of age,
- ☐ Score **NA** if the member is under 6 or over 18 years of age (e.g., 17 years and 365 days).

General Clinical Chart (GCC-5): High Needs Case Manager

Requirements/Guidelines: There is evidence within the clinical chart that if the child has a CALOCUS level of care, 4, 5, or 6, there is a high needs case manager assigned or there is documentation identifying why a high needs case manager is not assigned. (AMPM 320-O; AMPM 570)

Scoring Instructions: To be scored YES, the following MUST be met:

- ☐ An HNCM has been assigned to a child with a CALOCUS level of 4, 5, or 6, **OR** there is documentation to indicate why an HNCM is not assigned (e.g., option declined by parent/caregiver, health care decision maker),
- ☐ **Score NA** only if the member is younger than six or older than 18 years of age, **OR** for those children between six and 18 years of age that have a CALOCUS level of 1, 2, or 3.

General Clinical Chart (GCC-6): Point of Contact for Member Coordination

Requirements/Guidelines: There is evidence within the clinical chart that the member was made aware of how to contact the provider responsible for coordinating, planning, and/or delivering services and support. (AMPM 320-O; AMPM 541; AMPM 570)

The intent of this element is to ensure members are aware of their primary point of contact for care coordination. This may include but is not limited to a behavioral health case manager, an ALTCS-EPD Case Manager, or another designated provider responsible for coordinating or delivering care. For members enrolled in ALTCS-EPD, the assigned ALTCS-EPD Case Manager must be clearly identified in the chart, with documentation showing the member was informed how to contact them.

Scoring Instructions: To be scored YES, the following MUST be met:

☐ There is documentation within the clinical chart to demonstrate that the member was made aware of how to contact the provider responsible for coordinating, planning, and/or delivery of services and support.

General Clinical Chart (GCC-7): Collaboration

Requirements/Guidelines: There is evidence in the clinical chart that collaboration occurs across the delivery of care as other services or supports are identified to address member's needs. (AMPM 320-O; AMPM 541; AMPM 570)

The intent of this element is to verify that the provider is actively coordinating with other systems, providers, or agencies involved in the member's care. Examples of collaboration may include:

- Communication with behavioral health providers involved in additional treatment or support,
- Coordination with physical health providers, including the Primary Care Provider (PCP),
- Engagement with other systems such as DCS, DES/DDD, ADJC, ADCRR, or others as appropriate.

If the member is newly enrolled and collaboration has not yet occurred, documentation in the initial assessment that identifies the member as new to the system, along with the date of entry, may satisfy this requirement.

Scoring Instructions: Score YES if ANY of the following is met:

☐ Documentation demonstrates collaboration or coordination of care with other providers or systems involved in the member's care,

☐ **OR** the member declined collaboration and this decision is documented,

☐ **OR** the member is new to the system, and the assessment or clinical record reflects this with appropriate justification,

☐ **OR** the clinical documentation indicates that no external providers or systems are involved or needed at this time.

General Clinical Chart (GCC-8): PCP Coordination

Requirements/Guidelines: There is evidence in the clinical chart of communication between the behavioral health provider and the Primary Care Provider. (AMPM 510)

The intent of this element is to ensure integrated, safe, and accountable care through effective coordination with the PCP. Behavioral and physical health are intricately linked, and coordinated communication helps ensure that treatment planning reflects the member's full clinical profile. This may include, but is not limited to co-occurring conditions, psychiatric diagnoses, medications, and social determinants of health. PCP coordination reduces care fragmentation, enhances continuity, and improves clinical outcomes.

In addition, sharing current information with the PCP mitigates risks related to:

- Duplicate or conflicting prescriptions,
- Adverse medication interactions,
- Unmanaged side effects or contraindications.

Documented communication also supports smooth care transitions (e.g., hospital discharge), demonstrates provider accountability, and aligns with regulatory requirements for timely information sharing across systems of care.

Communication must include, at a minimum:

- Member's diagnosis,
- Medications (including strength, dosage or associated changes with strength or dosage)
- Contact name and phone number,
- Evidence that information was sent (e.g., fax confirmation, electronic message, integrated record).

Clarifying Guidance:

➢ Coordination should occur at the time of enrollment and at least annually, and within 30 days of a significant change in status, such as:

- Addition of a new medication,
- Discontinuation of a previous medication,
- Change in behavioral health diagnosis,
- Change in physical health condition.

If the member declines PCP coordination, the documentation must include the reason for refusal.

Scoring Instructions: To be scored ALL of the following MUST be met:

☐ Member's diagnosis and medication list (including strength and dosage) are documented and sent to the PCP upon enrollment and at least annually,

☐ If there was a significant change in diagnosis or medication, updated information was sent to the PCP within 30 days,

☐ If PCP coordination was declined, there is documentation of the member's refusal and rationale. Documentation includes contact name and provider phone number.

General Clinical Chart (GCC-9): Health Related Social Needs

Requirements/Guidelines: There is evidence in the clinical chart that health-related social needs were identified and, when necessary, coordinated across providers and community social service agencies. (Contract & Policy Dictionary; AMPM 320-O; AMPM 580; AMPM 582; AMPM 584)

The intent of this element is to ensure that providers proactively assess and, when necessary, coordinate support for social needs that may impact the member's ability to engage in treatment and achieve their service goals. These needs often influence physical and behavioral health outcomes and must be identified and addressed as part of whole-person, integrated care.

Health-related social needs (HRSN) may include, but are not limited to:

- Housing instability,
- Food insecurity,
- Financial strain,
- Utility assistance,
- Social isolation,
- Employment or education barriers,
- Environmental safety concerns.

Clarifying Guidance:

- There should be evidence that HRSNs were assessed and present,
- If HRSNs were identified, there should be documented coordination efforts.

Scoring Instructions: Score YES if the following is met:

☐ The chart shows that the member was assessed for health-related social needs **and** either

- Coordination efforts are documented when needs were identified, **OR**
- It is clearly documented that no needs were identified.

General Clinical Chart (GCC-10): Engagement/Re-engagement

Requirements/Guidelines: There is evidence in the clinical chart of engagement or re-engagement after identification of a behavioral health crisis, safety concern, or significant event. (AMPM 570; AMPM 1040)

The intent of this element is to assess whether the provider initiated timely and appropriate follow-up after significant events that may place the member at risk or disrupt continuity of care. Significant events may include:

- Discharge from an inpatient facility,
- Emergency Room utilization,
- Behavioral health crisis involvement,
- Changes in level of care,
- Missed clinical appointments.

Engagement and re-engagement to address follow-up after significant events may include:

- Direct outreach (calls, letters, texts),
- Care coordination or team meetings,
- Safety or crisis planning,

- Documented efforts to reschedule missed appointments or address barriers to care,
- Follow-up after missed clinical appointments.

Clarifying Guidance:

➢ Follow-up should be timely and aligned with clinical need:
- Within 7 calendar days following discharge from an inpatient or emergency department setting,
- Within 72 hours following a behavioral health crisis,

Scoring Instructions: Score YES if EITHER of the following is met:

☐ The member experienced a behavioral health crisis, inpatient discharge, ER visit, change in level of care, or missed appointment during the review period, and follow-up or re-engagement efforts were documented in accordance with the timeframes outlined above (e.g., 72 hours for crisis, 7 days post-discharge, or 1–3 business days for missed appointments), **OR**

☐ There is documentation in the clinical record confirming that no such events occurred during the review period (e.g., progress notes, assessments, or service documentation indicate clinical stability or continued engagement without disruption).

General Clinical Chart (GCC-11): Transition Age Youth

Requirements/Guidelines: There is evidence in the clinical chart that transition activities begin no later than 16 years of age or upon initiation of services for anyone entering services over the age 16 and not yet 18 years of age. (AMPM 520; AMPM 580; AMPM 584; AMPM 587)

The intent of this element is to ensure that youth receive timely and appropriate support in preparing for adulthood. Transition activities may begin earlier than age 16 if determined necessary by the CFT. Activities may include discussion of independent living skills, education or career planning, health care transition, and referrals to transition-specific providers or services.

Clarifying Guidance:

➢ Focus on broad activities related to transition planning, as opposed to a single focus on care coordination and transition from a children's provider to an adult provider, or completion of an SMI referral/evaluation.

➢ Transition planning (as identified in AMPM 587), evaluates guidance provided that relates to skills needed for effective transition to adulthood. Examples include, but are not limited to:
- Independent living skills and living arrangements,
- Vocational/Employment options and preparation,
- Educational options,
- Medical/Physical healthcare needs,
- Finance/budgeting,
- Legal considerations

Scoring Instructions: Score YES if the following is met:

☐ The chart shows documentation of transition to adulthood activities began at 16 years of age **OR** at initiation of services for anyone over the age of 16 and not yet 18 at the time-of-service initiation,

☐ **Score N/A Only if the following is met:** the member was under the age of 16 or over the age of 18 during the review period.

General Clinical Chart (GCC-12): SED Identification

Requirements/Guidelines: There is evidence in the clinical chart that the member has been referred for and/or offered an initial SED Eligibility Identification, or that the member/HCDM has declined the option for an SED Eligibility Identification, or there is documentation that an SED Eligibility Identification was not necessary based on diagnosis or functional limitations. (AMPM 550; Hyperlink: SED FAQs)

The intent of the Serious Emotional Disturbance (SED) Eligibility Identification element is to ensure children receive a prompt and accurate referral if a provider determines the need exists and/or if the HCDM requests an SED Eligibility Identification. If documentation indicates that a member's HCDM requests an SED Eligibility Identification or if there is documentation regarding the need for an assessment, there must be evidence within the clinical chart that an SED Eligibility Identification request has been made.

Member's HCDM can always decline an SED Eligibility Identification and therefore credit will be given for documenting that the HCDM has declined the eligibility identification. For members under 18 years of age, the qualifying diagnosis documentation will be present in the clinical record to demonstrate that an SED Eligibility Identification was offered.

Scoring Instructions: Score YES if the following is met:

☐ The member has been referred for and/or offered an initial SED Eligibility Identification, or the member/HCDM has declined the option for an SED Eligibility Identification, or there is documentation that an SED Eligibility Identification was not necessary based on diagnosis or functional limitations,

☐ **Score N/A only** when the member is over the age of 18 years of age **OR** member already has an SED identification.

General Clinical Chart (GCC-13): SMI Determination

Requirements/Guidelines: There is evidence in the clinical chart that the member has been referred for and/or offered an initial SMI Eligibility Determination and referred to the Determining Entity, or that the member/HCDM has declined the option for an SMI Eligibility Determination, or there is documentation that an SMI Eligibility Determination was not necessary based on diagnosis or functional limitations. (AMPM 320-P)

The purpose of this element is to ensure that members are promptly identified and referred for an SMI Eligibility Determination when appropriate, either at the request of the member/HCDM or when a provider identifies clinical indicators that suggest a determination may be warranted.

If a need or request for an SMI Determination is documented, the chart must reflect that a referral was made to the SMI Determining Entity. If a member or HCDM declines the determination, this decision shall also be clearly documented.

Clarifying Guidance:

- For members who are **17 years and 6 months of age or older** with a qualifying SMI diagnosis, the record shall demonstrate that the option for an SMI Eligibility Determination was offered.

Scoring Instructions: To be scored YES, ONE of the following MUST be met.

- ☐ The member was referred for and/or offered an initial SMI Eligibility Determination and referred to the Determining Entity,
- ☐ The member or HCDM declined the SMI Eligibility Determination, and this decision is documented,
- ☐ It is clearly documented that an SMI Eligibility Determination was not clinically indicated based on diagnosis or functional status,
- ☐ **Score N/A** only if the member is under the age of 17 years and 6 months old **OR** member already has an SMI designation.

General Clinical Chart (GCC-14): Special Assistance/SMI Designation

Requirements/Guidelines: There is evidence in the clinical chart to indicate members with a serious mental illness (SMI) designation have been assessed for Special Assistance. (AMPM 320-R)

The intent of this element is to ensure that providers identify and document whether a member with an SMI designation requires Special Assistance to participate effectively in treatment and service planning. Special Assistance is a formal support, not a treatment or service, and is intended to protect the rights of members who need help understanding or engaging in the behavioral health system.

Auditors must confirm that providers:

- Assess all SMI-designated members for Special Assistance eligibility,
- Document the outcome of the assessment, including member agreement or declination,
- Reassess periodically, or as required if the member is receiving Special Assistance,
- Automatically apply Special Assistance for members with a full/permanent HCDM,
- Inform the member of their right to appeal the Special Assistance determination (unless they have a permanent HCDM).

Scoring Instructions: To be scored YES, ALL of the following MUST be met:

- ☐ The member has an SMI designation,
- ☐ A Special Assistance assessment was completed,
- ☐ The outcome of the assessment is documented (e.g., qualifies, does not qualify, declined, or not needed,
- ☐ **Score N/A** only if the member does **NOT** have an SMI designation.

General Clinical Chart-(GCC-15): Impact of Service Planning

Requirements/Guidelines: There is evidence within the clinical chart that services are continually evaluated with the member/family to ensure there is progress with the member in meeting service plan goals. (AMPM 320-O)

The intent of this element is to ensure services are responsive, goal-oriented, and adjusted based on member progress, barriers, or changing needs. Reviewers should look for documentation that demonstrates:

- Active monitoring of service impact on member goals,
- Collaboration with the member/family in reviewing progress,
- Updates to services or service planning when goals are not being met,
- Follow-up on unmet services or identified barriers,
- Alignment of services with individual needs such as crisis stabilization, trauma recovery, placement stability, educational progress, and overall functioning.

Clarifying Guidance:

- *The service plan is current,*
- If progress notes do not reflect review of service plan goals, CFT or ART notes, with the member/family, adjustments when needed, or barriers or delays, then a yes score cannot be given.

Scoring Instructions: To be scored YES there MUST be evidence that:

- ☐ *The service plan is current (including the member/HCDM **and** BHP signature),*
- ☐ The provider reviewed progress toward service plan goals with the member/family, adjusted services when needed, and addressed any barriers or delays in service implementation.

SECTION IV: PERSON CENTERED PLANNING & TREATMENT ELEMENTS AND GUIDELINES

This section ensures that behavioral health services are responsive to the unique needs, values, and preferences of each member. Person-centered planning emphasizes collaborative decision-making, respects individual autonomy, and incorporates the member's cultural identity, beliefs, and language into every stage of care.

Audit elements in this section evaluate how effectively providers engage members and families in planning, support informed choice, and uphold member rights. When aligned with high-quality clinical practices and the core principles of recovery-oriented service delivery, person-centered planning helps ensure services are meaningful, individualized, and support long-term wellness.

Effective person-centered care relies on active collaboration, clear communication, and shared decision-making. Auditors should assess whether providers:

- Acknowledge and incorporate cultural customs, values, and language needs,
- Facilitate transparency around service options, member rights, and privacy,
- Engage members and families as equal partners in planning and treatment,
- Develop and coordinate personalized safety and crisis response plans,
- Promote transition readiness and continuity of care across settings.

This section reinforces the foundational principles of the Arizona Vision and System of Care, including member empowerment, dignity of risk, and shared responsibility for recovery outcomes. By consistently applying these principles, providers contribute to a behavioral health system that is collaborative, equitable, and grounded in the values of autonomy, respect, and resilience.

Person Centered (PC-1): Cultural Customs/Values/Beliefs/Structure

Requirements/Guidelines: There is evidence in the clinical chart that demonstrates the provision of culturally informed services that recognize the member/family as an expert of their own culture. (ACOM 320-O; AMPM 580; ACOM 405)

There is evidence in the clinical chart that culturally informed services were provided, recognizing the member and/or family as the expert of their own culture. Documentation should reflect the member's cultural identity, values, customs, traditions, and/or family structure as assessed and addressed within the following areas, as applicable:

- Assessment or Strengths, Needs, and Cultural Discovery (SNCD),
- Service Plan,
- CFT/ART documentation,
- Progress Notes or Care Coordination Records.

The intent of this element is to ensure the provider actively considers the member's cultural background decisions, supports, and interventions.

Scoring Instructions: To be scored YES, the following MUST be met.

☐ The member's or family's cultural preferences were assessed, considered, and incorporated into the member's treatment recommendations.

Person Centered (PC-2): Preferred Language-Oral

Requirements/Guidelines: There is evidence in the clinical chart that service providers assessed the need for qualified interpretation services to communicate (oral) in the preferred language of the member/family and provided the service if indicated as a need (e.g., bilingual staff, staff interpreters, contract interpreters, telephone interpreter lines, etc.). (AC

OM 405)

This element ensures that language preferences are addressed to support clear communication, member understanding, and culturally responsive care. Documentation should reflect both the identification of the preferred spoken language, and any accommodations made.

Scoring Instructions: To be scored YES, ALL of the following MUST be met:

☐ The member's or family's preferred spoken language was assessed, and

☐ There is documentation that qualified interpretation services were offered or provided, as needed, in that language, when indicated.

Person Centered (PC-3): Preferred Language-Written

Requirements/Guidelines: There is evidence in the clinical chart that service providers assessed the need for qualified translation services to communicate (written) in the preferred language of the member/family and provided the service if indicated as a need (e.g., bilingual staff, staff translators, contract translators, etc.). (ACOM 405)

Scoring Instructions: To be scored YES, ALL of the following MUST be met:

☐ The member's or family's preferred written language was assessed, and

☐ There is documentation that qualified translation services were offered or provided in the preferred written language, when indicated.

Person Centered (PC-4): Review of Services Options

Requirements/Guidelines: There is evidence within the clinical chart that the member was made aware of providers and the option to choose from an array of providers for services included on the service plan (voice and choice). (AMPM 300-3; AMPM 320-O; ACOM 405)

The intent of this element is to ensure that members are actively informed of their right to choose among an array of qualified service providers for services included in their service plan. This supports person-centered care, member empowerment, and voice and choice, as outlined in the Arizona Vision and the 9 and 12 Principles of the System of Care.

Providers must do more than distribute a member handbook. They are expected to engage in direct, documented conversations with the member about available provider options—such as health homes, outpatient behavioral health clinics, Community Service Agencies (CSAs), and peer- or family-run organizations—and support the member in making informed choices.

Acceptable documentation may include:

- Progress notes or service planning records that reflect discussion of provider options,
- Evidence that the provider offered a written or electronic list of in-network providers,
- Notation that the provider assisted the member in using the health plan's website or search tools to explore available providers,
- Documentation of the member's choice, including any declination or change in provider based on preference.

This process should affirm the member's rights to:

- Choose and change service providers at any time,
- Receive help accessing information about all covered services,
- Have their preferences reflected in the service plan and service delivery.

By engaging in these practices, providers demonstrate a commitment to collaborative, individualized care and respect for each member's autonomy and preferences.

Scoring Instructions: To be scored YES, the following MUST be met.

☐ The member was given provider options and the opportunity to accept or decline specific providers

Person Centered (PC-5): Member/Family Collaboration

Requirements/Guidelines: There is evidence within the clinical chart that progress notes demonstrate ongoing collaboration with the member/family and the provider is responsive to their input and preferences. (AMPM Exhibit 300-3; AMPM 320-O; AMPM 541; AMPM 570; AMPM 580; AMPM 583)

There must be clear, consistent evidence in the clinical chart that the provider engages in ongoing collaboration with the member and/or family throughout the course of care. **This includes documentation that:**

- The provider listens to and incorporates the member's and/or family's input,
- Services and interventions reflect their expressed preferences and evolving needs,

- Member/family feedback results in adjustments to treatment planning, services, or goals when appropriate.

This element reinforces the principle that treatment is most effective when members and families are active partners in care planning and delivery. Collaboration must be visible beyond the initial assessment or service plan—progress notes must reflect meaningful dialogue, shared decision-making, and responsiveness.

Clarifying Guidance:

- Documentation may appear in progress notes, CFT/ART meeting summaries, or service plan updates,
- The provider should not only document member/family attendance but also indicate how their input informed care decisions,
- One-time documentation of collaboration is not sufficient—there must be evidence of ongoing collaboration across the review period,
- Absence of documentation or generic language (e.g., "member agreeable") without specificity does not meet the standard.

Scoring Instructions: To be scored YES, ALL of the following MUST be met.

- ☐ There is documentation that the member and/or family actively participated in treatment planning or service delivery discussions,
- ☐ Progress notes reflect that the provider considered and responded to the member's or family's preferences, goals, or concerns,
- ☐ There is ongoing evidence of collaborative engagement—not just a single instance.

Person Centered (PC-6): Member Rights

Requirements/Guidelines: There is evidence in the clinical chart that the member was informed of their right to file a grievance and appeal. (42 CFR - Notice of Adverse Benefit Determination; ACOM 414)

The intent of this element is to ensure that members are aware of and empowered to use the grievance and appeal system to address concerns about their care, which reinforces transparency, procedural safeguards, and member autonomy.

MCOs must provide timely written notice to members when an adverse determination is made, and that notice must include:

- The member's right to file an appeal,
- The member's right to request a state fair hearing,
- How to file a grievance or appeal and the timeframe for doing so.

Clarifying Guidance:

- Providers should:
  - Document that members were informed of their grievance and appeal rights,
  - Include signed acknowledgments or case notes confirming this discussion,
  - Ensure this information is provided at enrollment, annually, and upon significant events (e.g., service denial or change).

- Examples of acceptable documentation include:
  - A signed grievance and appeal rights acknowledgment form,
  - A progress notes reflecting verbal explanation of these rights,
  - A member handbook review documented in the clinical record with clear reference to grievance and appeal rights,
  - Evidence that the member was informed of assistance available to help them file a grievance or appeal.

Scoring Instructions: Score YES, if AT LEAST ONE of the following is met:

☐ There is documentation confirming that the member was informed of their grievance and appeal rights,

☐ Progress note describing verbal explanation of grievance and appeal rights to the member/family,

☐ Documentation that grievance and appeal rights were reviewed during intake, service planning, or following a service denial/change,

☐ Other documentation showing the member was informed of how to file a grievance or appeal, including what assistance is available.

Person Centered (PC-7): Member Privacy

Requirements/Guidelines: There is evidence in the clinical chart that the member was informed of their HIPAA and privacy rights, which includes documentation of the appropriate release of information when necessary. (AMPM 940; HIPAA Home Page; HIPAA & Part 2)

This element ensures that providers meet AHCCCS expectations by informing members of their privacy rights and maintaining required documentation. **Timeline requirements occur at enrollment and at a minimum of once every three years.**

Clarifying Guidance:

- Documents that may provide evidence of ensuring member privacy:
- Provision of a HIPAA Notice of Privacy Practices (NPP) to the member,
- A member handbook review documented in the clinical record with clear reference to HIPAA and privacy rights,
- Documentation that the member acknowledged receipt of the NPP,
- Valid Release of Information (ROI) forms when coordinating with outside entities. Release of information only applies to substance use disorder.

Scoring Instructions: To be scored YES, the following MUST be met.

☐ There is documentation that the member was informed of their privacy rights under HIPAA, including receipt and acknowledgment of the Notice of Privacy Practices, and/or release of information forms for release of substance use treatment are present when applicable.

Person Centered (PC-8): Crisis/Safety Planning

Requirements/Guidelines: There is evidence in the clinical chart that crisis or safety concerns have been assessed and if concerns or a crisis event were identified, they were addressed in a crisis/safety plan, and coordinated as necessary across providers, based on needs identified within the crisis plan. (AMPM 320-O; AMPM 541; AMPM 570; AMPM 580; AMPM 590)

The intent of this element is to ensure that:

- Crisis or safety concerns are proactively identified,
- A personalized safety or crisis plan is developed when needed (annually at a minimum),
- Coordination of care occurs following a crisis event (e.g., after discharge from inpatient or crisis services).

Documentation must reflect the provider's response to any known or emerging safety risks, including steps to maintain member and community safety.

Scoring Instructions: To be scored YES, ALL of the following MUST be met:

☐ A current, individualized crisis/safety plan is in the chart addressing identified crisis or safety concerns,

☐ If there was a crisis, the provider coordinated needs or follow-up services with other involved entities following a crisis event if applicable (e.g., post-discharge, emergency room visit, or law enforcement contact).

Person Centered (PC-9): Advance Directive (Adults Only)

Requirements/Guidelines: There is evidence in the clinical chart that the member was provided with information about their right to create an Advance Directive, in accordance with AHCCCS requirements. (AMPM 640)

The intent of this element is to ensure that providers uphold adult members' legal rights to make decisions about their medical care, including the right to accept or refuse treatment and to execute or rescind an Advance Directive at any time. Documentation should reflect that the provider:

- Educated the member (or Health Care Decision Maker, if applicable) about Advance Directive options,
- Offered written information about the organization's policies on Advance Directives,
- Documented whether the member completed, declined, or did not have an Advance Directive.

Clarifying Guidance

- ➢ It is recommended that the auditor review for completion of Advance Directives at intake and based on updated significant behavioral or physical health changes.
  - If Advance Directives completed at intake are not immediately accessible, auditor can request copy of initial Advance Directives.

Scoring Instructions: To be scored YES, ALL of the following MUST be met.

☐ The member was provided written information about their right to create an Advance Directive,

☐ There is documentation indicating whether an Advance Directive has been completed, declined, or is not on file,

☐ **Score N/A** if the member is under the age of 18 at the time of review.

SECTION V: DCS CHP SUPPLEMENTAL AUDIT ELEMENTS AND GUIDELINES

DCS, with support from any subcontracted Managed Care Organization, and as part of its larger Quality Management System, shall conduct the Behavioral Health Clinical Chart Audit to meet requirements set

forth in AHCCCS Contract and Policy. DCS shall also meet the stipulations set forth within B.K. ex rel. Tinsley, et al. v. Faust, et al., CV-15-00185-PHX-ROS (August 14, 2020), the particular needs of children in foster care are met as identified:

(1) Whether the behavioral health assessments, evaluations, service plans, and CFTs for Class Members during the period under review were conducted in compliance with measurements as defined in the Clinical Chart Audit tool,

(2) Whether the Class Members during the period under review, received the services identified in, and in the timeframe contemplated by, their behavioral health service plans,

(3) Whether the behavioral health services received by Class Members during the period under review were effective.

Within AHCCCS Policy ACOM 449, Integrated Rapid Response (IRR) is defined as: *a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is referred and then dispatched within 72 hours to assess a child's immediate physical and behavioral health needs and to refer the child for additional assessments through the behavioral health system.*

- If the reviewer determines that Integrated Rapid Response did not occur as required or occurred with a previous provider that is not being audited, the reviewer will use initial assessment and service plan at the time the member was opened with the provider that is being audited to evaluate timeliness of Integrated Rapid Response elements below. The reviewer will review the complete clinical chart of the member as needed for audit completion.

As it relates to sampling of DCS CHP members and the look back period for collection, DCS CHP shall provide documentation within their BHCCA Findings and Summary Report of the following:

- Criteria and process for how the sample is pulled that includes how the subpopulations' cases are pulled:
  - Indicate sufficient number of cases to achieve 90% confidence level with a 10% margin of error;
  - Include subpopulation of children with the following:
    1. Children who have high needs case managers,
    2. Children who do NOT have high needs case managers,
    3. Children who have been placed with multiple caregivers.

Reviewers shall follow due diligence steps to ensure that if a child is pulled for the audit sample that does not meet the above criteria, that a replacement case be identified for a child that does meet the criteria.

DCS CHP-1 (DCS CHP-1): Requirements/Guidelines and Scoring:

Requirements/Guidelines: There is evidence in the clinical chart that services provided to the member were effective in addressing crisis.

The reviewer is to evaluate whether the services provided to the child were effective in addressing crises events that occurred during the review period. Reviewers should also consider if a safety plan is present within the clinical chart and if the child has been given appropriate support to use the preventative measures outlined in the safety plan to effectively prevent a crisis. If a child experienced a crisis during the review period, the reviewer should look for whether the crisis was responded to immediately and whether the intervention and disposition were appropriate given the identified needs

of the child including any updates to the safety plan to prevent future crisis events of the same nature. Crisis mobile response and subsequent follow-up in the first 24 hours following a crisis call are the responsibility of the ACC-RBHA. The reviewer should also consider whether the provider took appropriate follow-up action, post-crisis intervention including the following:

- Outreach to the child and family within a timeframe that meets clinical need,
- Modification to the crisis plan to address newly identified needs and prevent future crisis episodes within 72 hours,
- Modification to the services plan to address newly identified needs and additional services/supports implemented as determined necessary by the Child and Family Team,
- Re-evaluation of service intensity including the completion of the CALOCUS, and
- Prevent further escalation unless determined necessary, such as placement disruption, police intervention, hospitalization, mobile team, etc.

Scoring:

Yes: If a crisis was identified within the review period the clinical chart includes sufficient documentation indicating services provided to the member were effective in addressing each crisis event and interventions were developed to prevent future crises of the same nature.

No: If a crisis was identified within the review period the clinical chart does **not** include sufficient documentation indicating services provided to the member were effective in addressing crises. The member experienced a crisis and services on the member's service plan were not being provided **or** were not effective. The member experienced a crisis and appropriate follow-up actions did **not** occur to prevent future crises.

N/A: May only be scored N/A if there has not been a crisis within the time frame of the audit.

DCS CHP (DCS CHP-2): Reduced Placement Disruptions and Reduced Placements in More Restrictive Levels of Care

Requirements/Guidelines: There is evidence in the clinical chart that services provided to the member, reduce placement disruption and placement in more restrictive levels of care.

Referrals offered or scheduled appointments shall correspond to the services needed to reduce placement disruptions or placements in a more restrictive level of care. Documentation shall reflect the level of services provided and outcomes related to services delivered to prevent placement disruptions or more restrictive levels of care unless necessary for the health and welfare of the child. Documentation may be available within service plan updates, child/family team notes, or other clinical documentation utilized to demonstrate the effectiveness of services to reduce placement disruptions or placements in more restrictive levels of care. Documentation shall demonstrate efforts to ensure that any out-of-home placement is in the least restrictive environment for the welfare and clinical needs of the child. Multiple Out of Home placements within the review period should be reviewed and determined if clinically appropriate based on service level intensity.

For out-of-home and/or unplanned placement changes due to behavioral health symptoms reviewers will include:

- Emergency or unplanned placement changes over 24 hours,
- Shelter care placement,

- Treatment facility placement,
- Runaway episodes,
- Placements for juvenile justice purposes.

Reviewers will exclude:

- Visitation with siblings/relatives,
- Hospitalization (medical treatment, acute psychiatric episodes or diagnoses),
- Respite care,
- Day/summer camps,
- Trial home visits.

Scoring:

Yes: The clinical chart includes sufficient documentation indicating services provided to the member were effective at reducing placement disruptions and more restrictive levels of care OR if a member was placed out of home, documentation is present to justify that the level of care is the least restrictive to meet the member's needs.

No: The clinical chart indicates that the member experienced an unplanned placement disruption or out of home placement and documentation does **not** include sufficient evidence that services provided to the member were effective at reducing placement disruptions and more restrictive levels of care. The member is placed out-of-home and documentation does **not** sufficiently demonstrate that the member was placed at the least restrictive level of care to meet the member's needs.

N/A: May only be scored N/A if there has not been an out-of-home or unplanned placement change or disruption within the time frame of the audit.

DCS CHP (DCS CHP-3): Symptom Reduction

Requirements/Guidelines: There is evidence in the clinical chart that services provided to the member reduced symptoms.

The intent of this element is to determine if services provided to the member reduced symptoms. The reviewer should consider that recovery is not linear and an increase in symptoms during the review period does not necessarily indicate that the child is not in the process of recovering. Symptoms can be expected to ebb and flow throughout the review period, the reviewer should consider overall whether symptoms are improving or if a child is doing well if they are able to maintain stability in their recovery. It can be expected during times of change or transition in the DCS case that some children can experience an increase in symptoms. The reviewer will need to evaluate if clinically appropriate support was provided to minimize symptom escalation during these times. Documentation will be reviewed to determine if services were re-evaluated in preparation for periods of transition and if services were appropriately responsive to any increases in symptoms. Additionally, the review will evaluate if the services were clinically appropriate to overall reduction of the child's symptoms.

Scoring:

Yes: The clinical chart includes sufficient documentation (e.g., service plan goals, referrals and appointments) indicating services provided to the child were adequately meeting needs to promote symptom reduction. Documentation indicates that the child's symptoms improved and clinically appropriate support was provided to minimize symptom escalation.

No: The clinical chart does **not** include sufficient documentation (e.g., service plan goals, referrals and/or appointments), indicating services provided to the child were adequately meeting needs to promote symptom reduction. Documentation indicates that the child's symptoms have increased. Clinically appropriate services and supports were not in place or effective in reducing the child's symptoms.

DCS CHP (DCS CHP-4): Improvement in Educational Progress

Requirements/Guidelines: There is evidence in the clinical chart that services provided to the member improved the member's educational progress.

The reviewer will evaluate the clinical chart for ongoing assessment of educational needs. If a member has identified educational needs there is a subsequent service plan goal, services, and collaboration with the education environment to support the identified needs. Referrals offered or appointments scheduled shall correspond to the services needed for improvement in educational progress. Chart documentation may reflect that the member is performing well in school with no behavioral concerns. In this instance there are no identified needs, but ongoing assessment is required to ensure an appropriate response should a need arise. In evaluating whether the services provided to the child were adequately effective in improving educational progress, the reviewer should consider whether the services of the provider and CFT reflect a reasonable effort in addressing any identified barriers to progress.

Areas to consider include, but are not limited to:

- Assessments stating member's school status and needs,
- Service plans stating member's school related needs, goals, or services,
- Coordination with school staff/supports,
- School related updates documented in progress notes or CFT meeting notes.

In instances of newly identified educational needs during the review period, the reviewer should evaluate the CFT response, by determining if:

- A CFT meeting was scheduled,
- The service plan was updated,
- Referrals were made, and
- Services were implemented within the required 21-day timeframe.

Scoring:

Yes: The clinical record includes sufficient documentation (e.g., service plan goals, referrals and appointments) indicating services provided to the child were adequately meeting needs to promote educational progress. Documentation indicates identified educational needs were

being addressed **OR** that the provider was consistently reassessing the member for educational needs and/or support.

No: The clinical record does not include sufficient documentation (e.g., service plan goals, referrals and/or appointments) indicating services provided to the child were adequately meeting needs to promote educational progress. Chart documentation identifies an educational need, but the need has not been addressed **OR** there is no documentation within the clinical chart for the evaluation of potential educational needs.

N/A: May only be scored N/A if the member is not enrolled in school or of school age, beginning in Kindergarten.

DCS CHP (DCS CHP-5): Promotion of Natural Childhood Development

Requirements/Guidelines: There is evidence in the clinical chart that services provided to the member promote natural childhood development.

Clinical chart documentation includes assessment of child development and developmental history. If a provider has determined that a child is experiencing a delay, have appropriate referrals been made when necessary? Specifically, for this population of children it is possible to see regression in development due to transitions and/or trauma, the clinical chart should reflect ongoing evaluation of the member's development and additional services referred to support transitions and/or trauma related symptoms. Documentation may be available within service plan updates, CFT meeting notes or other clinical documentation utilized to demonstrate the effectiveness of services designed to promote childhood development.

In instances of newly identified developmental needs during the review period, the reviewer should evaluate the CFT response, by determining if:

- A CFT meeting was scheduled,
- The service plan was updated,
- Referrals were made, and
- Services implemented within the required 21-day timeframe.

Scoring:

Yes: The clinical chart includes sufficient documentation (e.g., service plan goals, referrals, and appointments) indicating services provided to the child were effective in promoting normal and natural childhood development. Documentation indicates identified developmental needs have been effectively addressed OR that the provider has regularly assessed and determined that the child's development is age typical and therefore there are no developmental needs.

No: The clinical chart does **not** include sufficient documentation (absence of service plan goals, referrals, and/or appointments) indicating services provided to the child were effective in promoting normal and natural childhood development. No evidence of ongoing evaluation of the member's development **OR** if a developmental need was identified and the member was **not** referred for appropriate support and/or services.

DCS CHP (DCS CHP-6): BHP Participation During CFT Practice

Requirements/Guidelines: There is evidence that the BHP participated in and provided oversight of the CFT Practice.

The intention of this element is to ensure documentation is present in the clinical chart that the BHP participated in and provided oversight of the CFT practice. BHPs may or may not attend all CFT meetings, but they are required to provide oversight of the CFT process. BHPs provide clinical oversight for the member's care by reviewing/signing off on assessments and services plans, offering clinical support and recommendations for treatment, completing the CFT Facilitation Supervision tool, etc.

BHP participation may be documented in CFT attendance records or in BHP signature on assessments and services plan. BHP participation may also be found in staffing notes that reflect the BHP offering clinical support and recommendations to individuals providing services to the member.

Scoring:

Yes: The clinical chart includes sufficient documentation indicating that a qualified behavioral health professional participates in the CFT process. Documentation includes record of BHP attendance in CFT meetings, BHP signature on assessments and service plans, and/or staffing notes that include BHP clinical recommendations

No: The clinical chart does **NOT** include sufficient documentation indicating that a qualified behavioral health professional participates in the CFT process. Documentation does **not** include BHP attendance in CFT meetings, BHP signature on assessments and service plans, and/or staffing notes that include BHP clinical recommendations.

DCS CHP (DCS CHP-7): CFT Frequency

Requirements/Guidelines: There is evidence in the clinical chart that CFT meetings are conducted at a frequency consistent with the needs of the child.

The intent of this element is to ensure that the CFT practice model is utilized to drive the development, integration, and unique individualization of service delivery. The level of complexity is determined individually with each child and family and documentation will include the team decisions regarding the frequency of CFT meetings scheduling.

The frequency of CFT meetings is individualized and scheduled in relation to the child and family's situation, preferences, and level of need. Therefore, no frequency of CFT meetings is required to support this individualized approach. The number of system partners involved and invited to participate in CFT practice by the child and family will contribute to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved. **CALOCUS screening tools will be reviewed, and the level of care indicated will be congruent with the level of identified needs of the member. Additionally, meeting frequency needs to be adjusted over time as the member's needs change.**

Scoring:

Yes: The clinical chart includes sufficient documentation indicating that CFT meetings are conducted regularly, and at a frequency consistent with the identified needs of the child. Meetings are held at a frequency that is consistent with documented team decisions regarding the needed frequency and adjustments to the frequency are made in relation to changes in needs.

No: The clinical chart does **not** include sufficient documentation indicating that CFT meetings are conducted regularly, and at a frequency consistent with the identified needs of the child. CFT meetings are consistently held at a frequency not congruent with the team-determined frequency.

DCS CHP (DCS CHP-8): DCS Attendance at CFTs Provider Invitation

Requirements/Guidelines: There is evidence in the clinical chart that the provider invited the DCS Specialist or DCS Specialist's supervisor to attend the CFT meetings.

The intent of this element is to ensure the provider is collaborating with DCS and inviting DCS to the CFT meetings as required.

Scoring:

Yes: The clinical chart includes sufficient documentation indicating that the assigned DCS Specialist, and/or DCS Specialist 's supervisor, were invited to attend all CFT meetings in person, by telephone, or electronically. Documentation indicates DCS specialist or DCS Specialist Supervisor is present in CFT meetings, **OR** if contact notes are present that include a CFT meeting invitation to DCS.

No: The clinical chart does **not** include sufficient documentation indicating that the assigned DCS Specialist, and/or DCS Specialist's supervisor, were invited to attend all CFT meetings in person, by telephone, or electronically. No record of DCS attendance or invitations sent to DCS.

DCS CHP (DCS CHP-9): DCS Attendance at CFTs

Requirements/Guidelines: There is evidence in the clinical chart that DCS Specialist or DCS Specialist's supervisor attends the CFT meetings in person, by telephone, or electronically.

The intent of this element is to ensure DCS attendance in CFT meetings. Providers are only responsible for inviting DCS Specialist but not at fault for DCS Specialist non-attendance.

Scoring:

Yes: The clinical record includes sufficient documentation indicating that the assigned DCS Specialist, or DCS Specialist's supervisor, attended all CFT meetings in person, by telephone, or electronically. Sufficient documentation shall indicate DCS specialist or DCS Specialist Supervisor is present in CFT meetings.

No: The clinical record includes sufficient documentation indicating that the assigned DCS Specialist, or the DCS Specialist's Supervisor, did **NOT** attend all CFT meetings in person, by telephone, or electronically. **OR** the clinical record does **not** include sufficient documentation indicating that the assigned DCS Specialist, or DCS Specialist's supervisor, did or did not attend all CFT meetings in person, by telephone, or electronically.

DCS CHP (DCS CHP-10): Behavioral Health and Medical History

Requirements/Guidelines: There is evidence in the clinical chart that available, relevant information about the child, including the child's behavioral health and medical history, is reviewed during CFT meetings.

Relevant documentation may include physical or behavioral health historical information gathered as part of the initial or ongoing assessment activities, previous CFT meetings or information garnered through coordination efforts with DCS, involved community stakeholders, or other behavioral health providers. All providers working with the member receive chart documentation at the time of referral and each time updates are made. CFT members receive copies of the service plan and crisis plans each time updates are made. If information about the child or the family/caregiver is shared during CFT meetings, it is important to follow trauma-informed care principles and recognize the potential for re-traumatization of the child (if present) or family members when sharing historical information. It is important to recognize provider limitations as it relates to HIPAA, the reviewer shall consider evidence that the provider made reasonable efforts to obtain necessary releases but was unable to share information without consent.

Scoring:

Yes: The clinical chart includes sufficient documentation indicating available relevant information about the child, including the child's behavioral health and medical history, was provided to CFT members, as appropriate. There is evidence within the clinical chart that documentation such as assessments, service plans, crisis plans, etc. including relevant behavioral health and medical history were provided to CFT members.

No: The clinical record does **not** include sufficient documentation indicating available relevant information about the child, including the child's behavioral health and medical history, which was provided to all CFT members. There is **no** evidence in the clinical chart that chart documentation containing the member's behavioral health and medical history was provided to CFT members as appropriate.

DCS CHP (DCS CHP-11): Integrated Rapid Response Referral for Initial BH Services - 7 Days

Requirements/Guidelines: There is evidence in the clinical chart that there is an initial evaluation within seven days of an Integrated Rapid Response referral.

The clinical chart shall include documentation to confirm timeliness requirements are met for the initial behavioral health service following a referral or request for behavioral health services. Each time there is an initial referral or subsequent initial request for a behavioral health service, a screening and evaluation occurred within 7 days. This evaluation may occur within a CFT meeting.

Scoring:

Yes: The clinical chart includes sufficient documentation indicating that an initial evaluation occurred within 7 days of a request or a referral for a behavioral health service. Documentation indicates that a CFT meeting or another appointment occurred within 7 days to evaluate the need of the request for behavioral health services.

No: The clinical chart does **not** include sufficient documentation indicating that the initial evaluation occurred within 7 days of the request or referral for a behavioral health service.

N/A: May only be scored N/A if an Integrated Rapid Response was not required within the time frame of the audit (e.g.. Member has been in placement for over a year and did not require an IRR).

DCS CHP (DCS CHP-12): Service Delivery Following Integrated Rapid Response

Requirements/Guidelines: There is evidence in the clinical chart that services have been provided at least once per month, following an Integrated Rapid Response referral for behavioral health services, subsequent to a rapid response.

The clinical chart shall include documentation to confirm chart compliance with the following requirement: the Contractor shall ensure that each child and family is referred for ongoing behavioral health services for a period of at least six months unless services are refused by the guardian, or the child is no longer in DCS custody.

Per Jacob's Law, Integrated Rapid Response referral would need to result in an assessment within 72 hours; therefore, the reviewer shall use 72 hours from DCS out-of-home placement as the IRR referral timeframe. If the IRR was completed late, the element will be scored from the 72 hours from DCS out-of-home placement in which an IRR is required.

Scoring:

Yes: The clinical chart includes sufficient documentation of ongoing services that are being provided at a minimum monthly for at least six months **OR** monthly since the Integrated Rapid Response, if less than 6 months ago.

No: The clinical chart does **not** include sufficient documentation of ongoing services that are being provided at a minimum, monthly since the Integrated Rapid Response.

N/A: May only be scored N/A if the member's first 6 months in out-of-home placement are outside of the audit review period.

DCS CHP (DCS CHP-13): Service Planning Following Integrated Rapid Response

Requirements/Guidelines: There is evidence in the clinical chart that members who received an Integrated Rapid Response referral for behavioral health services had an individual service plan completed in less than 90 days from their intake appointment.

The clinical chart shall include the member's individual service plan (ISP), which complies with AHCCCS policy and contract requirements for service plan standards completed in less than 90 days from their initial assessment.

In instances when the IRR was not done in compliance with the Jacob's Law timeframe, reviewers shall use the 72 hours from DCS out-of-home placement in which an IRR is required and not the timeframe the IRR was done. If the IRR was completed late, the element will be scored from the 72 hours from DCS out-of-home placement in which an IRR is required.

Scoring:

Yes: The clinical chart includes sufficient documentation indicating that an ISP was completed in less than 90 calendar days from the initial assessment.

No: The clinical chart does **not** include sufficient documentation indicating that an ISP was completed in less than 90 calendar days from the initial assessment OR the ISP in clinical record does not meet minimum AHCCCS requirements to be considered current and complete.

N/A: May only be scored N/A if an Integrated Rapid Response was not required within the time frame of the audit (e.g., Member has been in placement for over a year).

AHCCCS Housing and Health Opportunities (H2O) Program – Appendix

The AHCCCS Housing and Health Opportunities (H2O) program is a CMS-approved Demonstration initiative under Arizona's 1115 Medicaid Waiver. It aims to expand housing-related and supportive services for AHCCCS members who are experiencing or at risk of homelessness.

Eligibility: (Demonstration Period): H2O services are currently limited to AHCCCS members who meet all of the following criteria:

- Experiencing homelessness, and
- Have a Serious Mental Illness (SMI) designation, and
- Have a chronic health condition

OR

- Experiencing homelessness, and
- Have a Serious Mental Illness (SMI) designation, and
- Are currently incarcerated with a scheduled release within 90 days
- Were released from a correctional facility within the past 90 days

Program Administration & Provider Types: AHCCCS has contracted with Solari as the H2O Program Administrator to oversee implementation and evaluate program effectiveness.

Two new provider types have been established to support H2O goals:

- Enhanced Shelters
- Pre-Tenancy/Tenancy Service (PTTS) Providers

Care Coordination Expectations: Collaboration between H2O Providers and Health Homes is essential and contractually required. PTTS services are considered urgent and intensive.

Coordination includes the following:

- Involving PTTS providers in ARTs, ITDPs, and other care planning activities
- Ensuring Health Homes provide contact information to the H2O program
- Responding promptly to outreach from H2O providers and documenting care coordination in the member's chart
- Updating assessments and service plans once a member is housed, including any permanent supportive housing needs

For more details, visit the AHCCCS H2O Program page at:
https://www.azahcccs.gov/Resources/Federal/HousingWaiverRequest.html.