KEPRO

Behavioral Health CareConnection®

INSTRUCTIONS AND DEFINITIONS BY TIER: For completing the Behavioral Health Care Connection® offered by Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

INTRODUCTION

KEPRO utilizes the Behavioral Health CareConnection® to obtain clinical information necessary for the prior authorization of WV Medicaid Behavioral Health Services. The following instructions serve as a guide for FQHC and RHC providers on the submission of data related to Medicaid Behavioral Health Services.

The Behavioral Health CareConnection® https://careconnectionwv.kepro.com is an electronic, web -based application that is organized in a way that requires additional data elements as service intensity, duration or complexity increases. Various levels of data requirements are dependent upon the service(s) selected for prior authorization to meet a member's identified needs. All data elements demanded by the service selected must be completed for submission. In addition to submission via the web, completed requests may be sent through direct file transfer (i.e. EDI) to KEPRO.

These instructions are organized by presenting data elements as they appear within each level and are validated. Web users will only view the required items for submission for the particular service requested, and all items subject to validation must be completed before a record can be submitted.

The specific data level required for a service is described in provider-specific Utilization Management Guidelines that can be located at http://wvaso.kepro.com, under the Resources tab, Manuals and Reference section, for each provider type seeking prior authorizations for WV Medicaid Behavioral Health Services. Services are categorized related to the following data levels (Tiers) available to private practitioners:

1. Core Elements
2. Outpatient Data Requirements
3. Discharge Data Elements

Services requested determine the data level required to complete a submission. Low intensity services require Core elements while higher intensity or services provided at a frequency above the initial benefit require more clinical information for medical necessity determination. It is for this reason that continued stay requests or requests for additional service units may require a higher data demand than originally provided. These higher requirements are indicated in the Utilization Management Guidelines.

Discharge data elements have been included to signal the end of services with a WV Medicaid Member. These elements will assist in a uniform means of reporting discharges from your organization. The discharge data elements are not related to any specific service, but rather are available for completion for any service being provided.

Providers are encouraged to review the KEPRO website for additional clarifications about the instructions and the authorization process. The KEPRO homepage can be found at http://wvaso.kepro.com. All data entered onto the Behavioral Health CareConnection® with the exception of those noted should reflect the current clinical presentation of the member. Individuals gathering information regarding a member should have the appropriate behavioral health related training required to present complete and accurate clinical information.

Please note:

- By utilizing these instructions, completion of the demographic and clinical data elements will enable accurate and timely processing of the submitted request.
- Validation standards, as outlined in the Data Elements/Validation Standards document, for each field within the Behavioral Health CareConnection® data set will be applied to each record.

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Behavioral Health CareConnection®

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CORE ELEMENTS/TIER 1

Demographic and basic clinical elements are included within this tier. Providers will complete this information and receive an authorization number for these services.

Behavioral Health CareConnection® Completion Date: (Agency_Request_Date) The date the provider completes the Behavioral Health CareConnection® data for submission for prior authorization. The information submitted must reflect the member's clinical and demographic information at the point in time the Behavioral Health CareConnection® is completed. The only exception to this rule is for retrospective requests. In those circumstances, the completion date should reflect a current date although the clinical information presented should be reflected as it was on the start date of the service request.

Retrospective Request: (Retrospective_Request) Is this a retrospective authorization request? Please indicate the reason for the retrospective request in the free text field.

Case Status of Member: (Case_Status) Report the most applicable status from the options below. Retrospective requests may be submitted by checking 'Yes' to the question, "Is this a retrospective request?" on the initial submission screen.

- **New Admission:** A Member that has never received services with your organization prior to this visit. When this status is selected, a unique provider assigned member identification number is entered in the Member ID field. This ID number will remain the same for member throughout the span of services from your organization.

- **Readmission of a Discharged Case:** Member is returning for services following a past discharge from your organization. When this status is selected, the previous member identification number utilized at first admission is entered in the Member ID field.

- **Update:** Member is a current recipient of services and an authorization request is being submitted to continue or modify services within the current level of care provided through your organization. The Member ID should remain the same as previously entered at first admission.

- **Discharge:** Member is no longer receiving services from your organization. Selection of this case status will adjust the end dates of any open authorization. On the discharge screen, the date indicated by the provider as the last date of service will become the end date of any open authorization.

- **Crisis:** This case status is typically not used by private practitioners. In the event a service is provided to a member not known to your practice and there are no plans to continue services, you may select this option.

- **Change in Level of Care:** Change in the member's services that are more or less intensive than those most recently received by the member. The change in service mix is based upon a change in the clinical presentation of the member.

Note: All Behavioral Health CareConnection® records, regardless of the case status reported, are subject to all validation standards as outlined in the Behavioral Health CareConnection® Data Elements/Validation Standards document available at http://wvaso.kepro.com under the Resources tab, Data Submission section.

Clinician's Last and First Names: (Clinician_Name) Complete the field with the last and first name of the clinician completing the Behavioral Health CareConnection®. If the last name is hyphenated, include both in the field for last name. When multiple individuals complete portions of the data set, indicate the name of the individual who has primary responsibility for the implementation and tracking of the member's care.

Clinician's Phone Number: (Clinician_Phone) List the telephone number (including area code) of the clinician noted in the Clinician Last and First Name field.

Last Name of Member: (Consumer_Last_Name) Report the member's last name in this field. If the member has a hyphenated name include both names with the hyphen in the field.

First Name of Member: (Consumer_First_Name) Report the member's name as it would appear on his/her WV Medicaid card. Avoid the use of any nicknames and/or abbreviations of names.

Middle Name of Member: (Consumer_Middle_Name) Report the member's middle name. Leave blank if unknown or none.

Member's Mailing Address: (Consumer_Address) Indicate the member's current mailing address.

Member's City: (Consumer_City) Indicate the city in which the member lives.

Member State: (Consumer_State) Enter the state of the member's residence.

Member Zip Code: (Consumer_ZipCode) Enter the zip code of the member's address.

Provider-Assigned Member Identification Number: (Consumer_ID) This is a unique identifier for the member that follows him/her throughout their course of treatment with your organization. If the member is discharged and then returns, the same unique identifier is to be used for the member. This identifier cannot be reassigned to any other member receiving services from you at any time.

Medicaid Beneficiary Number: (Consumer_Medicaid_Number) This is the member's eleven (11) digit Medicaid number. Do not include any hyphens or the decimal point before the suffix.

NOTE: KEPRO conducts Medicaid eligibility verification. Behavioral Health Services provided to members with Special Medical cards are subject to prior authorization. These services are submitted for prior authorization like any Medicaid services and are subject to the same validation and clinical review standards to establish medical necessity.

Member's County of Residence: (Consumer_County) The county in which the member currently resides is represented by a 2-digit code.

NOTE: For children in DHHR custody, who may be placed in a county different from their home county, please code the child's county of origin. This is the county where the case originated. (Report the County where the Youth's DHHR worker is assigned.)

County	Code
Barbour	01
Berkeley	02
Boone	03
Braxton	04
Brooke	05
Cabell	06
Calhoun	07
Clay	08
Doddridge	09
Fayette	10
Gilmer	11
Grant	12
Greenbrier	13
Hampshire	14
Hancock	15
Hardy	16
Harrison	17
Jackson	18
Jefferson	19

County	Code
Kanawha	20
Lewis	21
Lincoln	22
Logan	23
McDowell	24
Marion	25
Marshall	26
Mason	27
Mercer	28
Mineral	29
Mingo	30
Monongalia	31
Monroe	32
Morgan	33
Nicholas	34
Ohio	35
Pendleton	36
Pleasants	37
Pocahontas	38

County	Code
Preston	39
Putnam	40
Raleigh	41
Randolph	42
Ritchie	43
Roane	44
Summers	45
Taylor	46
Tucker	47
Tyler	48
Upshur	49
Wayne	50
Webster	51
Wetzel	52
Wirt	53
Wood	54
Wyoming	55
Out of state	56

Member's Verified Social Security Number: (SSN) This is the member's nine-digit social security number. If the social security number is not known, all nines (9) may be entered.

Member's Birth Date: (Consumer_Birth_Date) Report the member's date of birth in mm/dd/yyyy format.

Member's Gender: (GENDER) Indicate whether the member is a male or female.

Member Marital Status (Consumer_Marital_Status) Indicate the marital status of the member.

- **Single**
- **Married**
- **Divorced**
- **Widow/Widower**
- **Separated**
- **Never Married**
- **Unknown/Not Available**

Member's Source of Referral to Provider: (Consumer_Referral_Source) Identify the choice that best describes the provider or person who referred the member to your organization. (Choose one (1) from the following list.)

- **Advocacy Provider**
- **Alcohol Inpatient/Residential Program**
- **Behavioral Health Organization**
- **Community Residential Organization**
- **Court or Correction Provider**
- **Developmental Disabilities Program**
- **Drug Abuse Inpatient Residential Program**
- **Drug Court**
- **Employer/Employee Assistance Program**
- **Family or Friend**
- **General Hospital Psychiatric Program**
- **Homeless/Abuse Shelter**
- **Individual/Self**

- **Information and Referral Provider**
- **Inpatient/Psychiatric Hospital**
- **Mental Hygiene**
- **Multi-Disciplinary Team (MDT)**
- **Multi-Service Mental Health Provider**
- **Nursing Home/Extended Care**
- **Other Inpatient/Residential Program**
- **Other Physician**
- **Other Private Pay Mental Health Practitioner**
- **Other Referral Source**
- **Outpatient Alcohol Program**
- **Outpatient Drug Program**
- **Outpatient Psychiatric Provider**
- **Partial Day Organization**
- **Police**
- **Private Psychiatrist**
- **School System or Education Provider**
- **Social Services Provider**
- **State or County Psychiatric Program**
- **WVDHHR**

Member's Participation Status: (Consumer_Participation_Status) Identify the member's type of participation related to receiving behavioral health services. Types may vary over time and should be modified to reflect the participation status at the time of completing the Behavioral Health CareConnection®. Members may seek services voluntarily and then become court-ordered or develop the need for emergent services.

- **Voluntary:** Member elects to seek services based upon their own choice.
- **Involuntary:** Member has been placed in service because of the mental hygiene process.
- **Emergent:** Member requires services quickly related to a behavioral health crisis.
- **Court Ordered:** Member has been legally mandated by a court to receive services. When services are sought related to involvement with a MH/Drug Court, this type should be selected. Note: When this participation status is chosen, the clinical presentation exhibited on the Behavioral Health CareConnection® must continue to meet medical necessity for the services requested.
- **Observation:** Member is being observed prior to admission to an inpatient service to determine the appropriate course of treatment.

CLINICAL INFORMATION: EVALUATION AND ASSESSMENT

Member's Disability Group: (Consumer_Disability_Group) Select the group that reflects all the diagnostic categories of the member's diagnoses. For example, the provider would select "Mental Health & Substance Abuse" disability group if the member had both a mental health and substance abuse diagnosis.

Note: Public Inebriate (PI) Services are primarily funded by the Bureau for Behavioral Health and Health Facilities (BBHHF). If any Medicaid service is required for a PI member, a prior authorization request for that specific service must be submitted.

All Behavioral Health CareConnection® records, regardless of the disability group reported, are subject to all validation standards as outlined in the Behavioral Health CareConnection® Data Elements/Validation Standards document available at http://wvaso.kepro.com under the Resources tab, Data Submission section.

Children ages 0 -3: Prior Authorization is not required for young children (age zero to three) who have been determined Part H Early Intervention eligible. The Office of Maternal, Child, and Family Health submits a listing of eligible children who are exempt

from the individual service prior authorization process. Any child not on this listing must have the relevant services listed on their IFSP and must have a prior authorization for the individual service **(see Appendix I of the KEPRO Utilization Management Guidelines Version 1.2 for more information regarding determining medical necessity for this population)**. The disability group for these children should be designated as Early Childhood/ Intervention.

- **Mental Health**
- **Substance Abuse**
- **Intellectual/Developmental Disability**
- **Mental Health & Substance Abuse**
- **Mental Health & ID/DD**
- **Substance Abuse & ID/DD**
- **Mental Health & Substance Abuse & ID/DD**
- **Early Childhood/Intervention**
- **PI (Public Inebriate)**

Diagnosis One: Report the primary DSM/ICD diagnosis. The diagnosis must be reported as it is presented in the DSM/ICD Manual. This will be the diagnosis which is reported with the Medicaid billing. If the member has no diagnosis, report the corresponding code in this field.

At the time of admission, a diagnosis may not be known; therefore, entries of either no diagnosis or diagnosis deferred are permitted when requesting initial evaluation services.

NOTE: Any Rule Out diagnosis or clinical impression should not be coded. These may be noted in the free text field as appropriate.

Diagnosis Two: Complete when a member has more than one DSM/ICD diagnosis. Indicate one additional (secondary) diagnosis in this field. The diagnosis must be reported as it is presented in the DSM/ICD Manual. If there is no secondary diagnosis, report no diagnosis.

Diagnosis Three: Include a third diagnosis if present. The diagnosis must be reported as it is presented in the DSM/ICD Manual. If there is no tertiary diagnosis, report no diagnosis.

NOTE: There are a total of 5 fields to enter diagnoses. If more than five (5) diagnoses are present, please list additional diagnoses in the free text field and/or the additional diagnosis field located within the Outpatient Tier.

TREATMENT/SERVICE PLAN STATUS

Treatment Plan Summary 1: (Treatement_Plan_Summary1) Indicate the primary problem area addressed on the member's individualized treatment plan. This area should be consistent with the primary problem, diagnosis, symptoms and functional deficits identified and communicated through the Behavioral Health CareConnection®.

Note: "Assessment/Evaluation Only" is the appropriate response to Treatment Plan Summary 1 when the member is being evaluated for a suspected behavioral health condition and/or referred for psychological testing only.

Current Treatment Plan Status: (Treatment_Plan_Type) This field relates to the treatment strategy. If the member is new to your organization and the strategy is being developed, indicate Initial. For subsequent submissions for the member, select Master.

Current Treatment Plan Status Options: (Treatment_Service_Plan_Status) Select the most appropriate field to indicate reasoning for adjustments to the existing treatment strategy.

- **Recent Admission:** Use when member is new to your organization for services and the initial plan is formulated.
- **Current Plan Maintained with No Progress:** Plan is sufficient to address needs although progress is not measurable at this time.
- **Current Plan Modified with Changes in Both Services and Intensity:** A change in the Member's clinical presentation indicates an adjustment to the services the member is receiving and their frequency and/or duration.
- **Current Plan is Modified with Changes in Intensity of Service:** The Member's clinical presentation indicates either an increase or decrease in the intensity of existing services received.
- **Current Plan is Modified with Changes in Service Array:** The Member's clinical presentation indicates an adjustment in the services received is necessary.
- **Current Plan Maintained with Progress but Goals Not Met:** Member has made progress so current plan will be continued.

Case Discussion Text Field: (Case_Discussion_Text_Field) Convey additional information related to the member's clinical status and/or related to resolving an issue with an authorization request (e.g. client is transferring from another provider, request number of units, etc.) This field may be left blank.

This completes the initial data elements for FQHC's and RHC's. The following data elements begin the Outpatient/Tier 2 data set.

OUTPATIENT DATA ELEMENTS (TIER 2)

Member's Race: Please select from one or more categories based on the member's designation of his/her own race. At least one race designation must be made.

- **American Indian (Race_American_Indian)** A person having origins in any of the original peoples of North and South America (including Central America and excluding Alaska), and who maintains tribal affiliation or community attachment.

- **Alaska Native (Race_Alaska_Native)** A person having origins in any of the original peoples of Alaska and who maintains tribal affiliation or community attachment.

- **Asian (Race_Asian)** A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand and Vietnam.

- **Black/African American (Race_Black_African_American)** A person having origins in any of the black racial groups of Africa.

- **Hawaiian/Pacific Islander (Race_Hawaiian_Pacific_Islander)** A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

- **White (Race_White)** A person having origins in any other original peoples of Europe, the Middle East or North Africa.

- **Other Race (Race_Other)** A person having origins not included in the six race designations above or a person with origins in multiple race designations listed above.

Member's Ethnicity: (Consumer_Ethnicity) Indicate the member's ethnicity from the following choices.

- **Puerto Rican**
- **Mexican**
- **Cuban**
- **Other Specific Hispanic**
- **Not of Hispanic Origin**
- **Hispanic—Specific Origin Not Collected**
- **Not Available/Unknown/Not Collected**

ID/DD without DSM-V Diagnosis: (IDDD_WO_DSMIV_Diag) If the member meets the State's definition of Developmental Disability, but does not have a DSM/ICD diagnosis, choose yes. If the member does not meet the State's definition of Developmental Disability and does not have a DSM/ICD diagnosis, indicate no.

EDUCATION

Grade Level: (Grade_Level) Select one that reflects the member's grade level completed. (If member has completed 4 ½ years of school, for example, "Four Years" would be the correct response.)

- **Zero Years**
- **One Year**
- **Two Years**
- **Three Years**
- **Four Years**
- **Five Years**
- **Six Years**
- **Seven Years**
- **Eight Years**
- **Nine Years**
- **Ten Years**
- **Eleven Years**
- **Twelve Years**
- **Thirteen Years**
- **Fourteen Years**
- **Fifteen Years**
- **Sixteen Years**
- **Seventeen Years**
- **Eighteen Years**
- **Nineteen Years**
- **Twenty Years**
- **Twenty Years +**

School Type: (Educ_Status) If member is in school, indicate the choice that most accurately describes the current schooling being received. If not in school, select that option.

- **Kindergarten**
- **Preschool Program**
- **Headstart**
- **Regular Education**
- **Special Education**
- **Alternative School**
- **GED Program**
- **Homebound**
- **Trade, Vocational or Technical**
- **College (2 or 4 Year Program)**
- **Graduate School**
- **Post Graduate**
- **Not in School**

EMPLOYMENT

Employment Status: (Employment_Status) Report the response that describes the member's current employment status:

- **Competitive Employment, Full-Time**
- **Competitive Employment, Part-Time**
- **Disabled: Not In Labor Force**
- **Homemaker: Not In Labor Force**
- **In Employment Training**
- **Inmate in Institution: Not in Labor Force**
- **Not Employed, But Looking**
- **Not Employed, Not Looking**
- **Not in Labor Force—Other**
- **Physically Impaired: Not In Labor Force**
- **Retired: Not In Labor Force**
- **Sheltered Work**
- **Student: Not In Labor Force**
- **Supported Work**
- **Volunteer**

LIVING ARRANGEMENTS

Member's Current Living Arrangement: (Consumer_Living_Arrangement) Choose one of the following allowed responses that best describes the member's current living arrangement:

Note: Typically, individuals younger than 18 years old should not be classified as "Own or Rent Non-Subsidized House/Apt." If they are living with biological parents, relative or foster family, please select from those options.

- **Acute Care Psychiatric Facility***:* the individual is currently placed in a short-term psychiatric facility.
- **Adoptive Home:** the individual lives with an adoptive parent(s).
- **Adult Correction Facility***:* the adult is currently placed in an adult correctional facility (prison or jail).
- **Adult Drug/Alcohol Rehabilitation Center***:* the individual is an adult and is currently placed in a 24-hour treatment setting that provides treatment for drug and alcohol abuse/dependence.
- **Adult Family Care Home***:* The adult resides in the home of a provider who cares for one or more individuals with care and support needs. Care and support are provided in a family-like environment. The individual generally has minimal need for

behavioral health treatment. Required treatment services are provided from resources in the community.

- **Dependent Living (Includes Halfway House):** the individual requires specific support and is in a living setting with individuals who require like support to maintain activities of daily living. The nature of the support is not specific treatment but is provided in the milieu (e.g. Halfway House for recovering alcoholics). Necessary behavioral health treatment services are provided from resources in the community.

- **Family Emergency Shelter***:* the individual resides with one or more family members in a facility that provides shelter to families that are victims of disaster, domestic violence, homelessness or other circumstances that have resulted in a disruption in the living environment.

- **Home of Biological Parents:** the individual lives with one or both of their biological parents.

- **Home of Friend:** the individual lives in the home of a person who is not a relative.

- **Home of Relative:** - the individual lives in the home of a person(s) that is related by virtue of blood or marriage.

- **Homeless/Homeless Shelter***:* the individual is staying in a facility set up to provide shelter and/or services to homeless persons or the individual is currently homeless and has no residence. This includes persons living in condemned buildings, living on the streets, or staying briefly with friends or relatives but having no permanent address. Youth residing in a shelter specifically serving runaways and homeless youth not in DHHR custody should be included in this living arrangement.

- **ICF/IID Group Home:** the individual resides in a licensed Intermediate Care Facility for individuals with intellectual disabilities(ICF/IID).

- **Independent Living Group Home***:* the individual resides in a facility with other individuals who perform the activities of daily living with minimal supervision and support. The individual generally has minimal need for behavioral health treatment. Required treatment services are provided from resources in the community.

- **Individualized Staff Setting (ISS)***:* staff is assigned to the individual to provide treatment, supervision and support up to 24 hours day due to specific behaviors or needs of the individual. The staff support can be provided in a variety of living settings. This option should not be chosen for individuals in 24-hour residential settings who may require 1:1 staff for periods of time due to specific behaviors. Necessary behavioral health treatment services are provided from resources in the community.

- **Inpatient Psychiatric Facility (Behavioral Medicine Unit):** the individual resides in a hospital based distinct unit. These units are identified as Behavioral Medicine Units (BMU) and have a separate provider number than the hospital.

- **Large Group Board & Care Home:** a supervised setting of more than eight (8) persons where room, board, supervision and assistance with activities of daily living are provided. Necessary behavioral health treatment services are provided from resources in the community.

- **Long-Term Psychiatric Facility***:* the individual is currently placed in a psychiatric facility that provides long-term care.

- **Medical Hospital***:* the individual is currently in a medical hospital for an illness or injury that requires an inpatient stay. Necessary behavioral health treatment services are provided from resources in the community.

- **Nursing Home**: the individual resides in a setting that provides care for persons (as the aged or chronically ill) who are unable to care for themselves.

- **Other***:* this includes any living arrangement not specified in this list. If this response is chosen, please identify the living arrangement in the free text field.

- **Own or Rent Non-Subsidized House/Apartment:** the individual lives independently in a home or apartment and does not receive federal or state assistance to pay rent or mortgage.

- **Personal Care Home***:* the individual resides in a setting licensed as a personal care home. Necessary behavioral health services may be provided off-site but are targeted in areas where the individual can achieve independence or to reduce specific symptoms to maintain the individual in personal care.

- **Private Boarding House:** the individual pays rent at a private boarding house (this living arrangement generally includes a provision for board or includes access to cooking facilities).

- **Psychiatric Residential Treatment Facility (21 Years and Less)***:* the youth resides in a facility that is classified as a psychiatric residential treatment facility (PRTF).

- **Regular Foster Home***:* the individual is placed in an approved foster home and has minimal need for behavioral health treatment. Required treatment services are provided from resources in the community.

- **Residential Group Treatment***:* the individual resides in a 24-hour, group, supervised setting where behavioral health treatment is provided as part of the daily program.

- **Rest Home***:* the individual resides in a setting that provides care for the aged or convalescent. Necessary behavioral health treatment services are provided from resources in the community.

- **Rooming House, Hotel, and YMCA:** the individual pays rent on a single room in a boarding house, hotel, or YMCA on a regular basis (e.g. weekly, monthly).

- **Small Group Board & Care Home:** a supervised setting of eight (8) or less persons where room, board, supervision and assistance with activities of daily living are provided. Necessary behavioral health treatment services are provided from resources in the community.

- **Specialized Family Care Home***:* the individual resides in the home of a provider who cares for one or more individuals with specific medical or behavioral health care needs. Care and support are provided in a family-like environment and behavioral health treatment services are provided either on or off site.

- **Subsidized Rental House/Apartment:** the individual lives independently in a home or apartment and receives federal or state assistance with rent or mortgage payments (e.g. HUD subsidy).

- **Supported Housing – Staff Supported:** the individual lives in their own home or apartment but paid staff are assigned up to eight (8) hours per day to assist the member in completing activities of daily living.

- **Treatment Foster Home***:* the individual is placed in an approved foster home that provides specialized treatment within the home setting as well as accessing behavioral health treatment resources and professionals from the foster care provider.

- **Wilderness Camp:** the individual is placed in a therapeutic wilderness program. Necessary behavioral health services are included in the service.

- **Youth Correction Facility:** the youth is currently placed in a Correctional Facility (e.g. Salem) or a Detention Facility.

- **Youth Drug/Alcohol Rehabilitation Center:** the individual is 0-17 years of age and is currently placed in a 24-hour treatment setting that provides treatment for drug and alcohol abuse/dependence.

- **Youth Emergency Shelter***:* the individual resides in a facility that provides shelter to youth who are in need of a temporary living arrangement due to a disruption in their living situation.

Length of Current Living Arrangement: (Length_Live_Arrange) Indicate the number of months the member has lived in the living arrangement indicated in the Living Arrangement field above. If the member is currently homeless, list the number of months he/she has been homeless, if known. For children who have a history of placement out-of-home and are currently at home indicate the length of stay since the current reunification (not total length of time in the home since birth).

Note: Convert years to months and report the total number of months in this field. If the member has been in their current residence less than one month, code as 1.

Risk of Losing Living Arrangement: (Loss_Live_Arrange) Indicate the choice that most accurately describes the member's risk of losing his/her current living arrangement.

- **Not at Risk**
- **At Risk**
- **Currently Out of Home Placement**

NOTE: Risk is determined differently for each type of case and the assessment is based on the stability/permanency of the member's present placement.

For children and youth: If the case is a child welfare case, the youth is at risk if it is possible that the youth's caregiver will not be able to continue to care for the youth. This may be due to abuse, neglect, abandonment or because the caregiver is physically unable to care for the youth.

If the youth is a juvenile justice case, the youth will be identified as at risk if he/she is a risk to the community when placed in his/her home. The probation officer must identify that the youth is at risk of being placed out of the home. If the youth is receiving mental health services, the psychological must state that the youth is at risk of being placed out of the home.

If the youth is in custody and currently placed out of home, response "Currently Out of Home Placement" is appropriate. If an individual is homeless and there is little likelihood for placement, indicate "Not at Risk."

LEGAL SECTION

Protective Services: (Protective_Services) Select the choice that accurately describes if the member is currently or has previously been involved with Child or Adult Protective Services.

- **Never**
- **Currently**
- **In the Past**

Youth Services recipients are not considered CPS involved unless there have been child abuse or neglect complaints and/or findings.

Member Legal Status: (Consumer_Legal_Status) This field is designed to reflect the legal status of both adults and children during treatment. *Choose the one (1) that best describes the member's current legal status.*

Some responses are designated for youth only and others for adults only. "No legal problems" is a valid response for both adults and youth. If a choice is made that is not valid for the member's age group, it will result in an error.

Choices for **both** age groups are listed below. Please select those (one or more) which best categorizes the legal issues relative to the member's lifetime.

- **Non-Adjudicated (Delinquent or Status Offender)- *Youth Only***
- **Dependent (DHHR custody due to abuse, neglect or abandonment)- *Youth Only***
- **Adjudicated Delinquent- *Youth Only***
- **Adjudicated Status Offender- *Youth Only***
- **No Legal Problems- *YOUTH or ADULT***
- **One or More Arrests- *Adults Only***
- **Involuntary Commitment (Civil)- *YOUTH or ADULT***
- **Involuntary Commitment (Criminal Justice)- *YOUTH or ADULT***
- **MH/Drug Court- *YOUTH or ADULT***

Non-adjudicated youth (delinquent or status offender) are those juveniles involved with the juvenile justice system who have not been convicted of an actual crime. These youth may be involved at any level from informal prevention programs to awaiting a hearing.

Dependent refers to those juveniles who are in West Virginia Department of Health and Human Resources custody for issues not related to a crime. These include, but are not limited to: abuse, neglect, and/or abandonment. Custody may also be given to WVDHHR when the family cannot meet a youth's treatment needs.

Adjudicated Delinquent refers to those youth who have committed an act that would be considered a crime if committed by an adult. Examples are drug offenses, shoplifting or malicious wounding.

Adjudicated Status Offender refers to youth who have been convicted of a crime only applicable to a minor. These offenses are incorrigibility, runaway, truancy and/or underage drinking.

No legal problems indicate that the youth or adult has had no contact with the court for delinquency or dependency proceedings.

Involuntary Commitment (Civil) are effected under Article 5 of Chapter 27 of the West Virginia Code in a civil proceeding whereby a person is found to suffer from addiction or a mental illness and, if not confined, is likely to cause harm to self or others.

Involuntary Commitment (Criminal Justice) results from a finding under Article 6A of Chapter 27 of the West Virginia Code that the defendant in a criminal action as a result of mental illness or addiction is either incapable of standing trial or not responsible for the actions which constitute the conduct which led to criminal charges being filed against him/her.

MH/Drug Court: Treatment-based alternatives to prisons, detention facilities, jails, and probation. These courts make extensive use of comprehensive supervision, drug testing, treatment services, immediate sanctions, and incentives.

One or more arrests If an adult has been arrested on any legal charge choose this selection and identify if the offense was within current treatment or lifetime.

Member Lifetime Legal Status: (Consumer_Legal_Status_Lifetime) Indicate whether the member has a prior legal status from the choices above.

GUARDIANSHIP

Guardianship: (Guardianship) Indicate by responding Yes or No whether the member has a legal guardian.

A legal guardian must be indicated for persons under the age of eighteen (18) unless the individual is an emancipated minor. The guardian is the person(s) who has legal responsibility for the individual or has been appointed by the court.

In the case of an adult, guardian refers to a person appointed by the court who is responsible for the personal affairs of a protected person and (where the order clearly indicates) the guardian may mean a limited guardian.

When the member does not have a legal guardian and the response to this item is “No” the guardian description and guardian information fields do not need to be completed.

TREATMENT SERVICE HISTORY

Indicate whether the member has received treatment in any of these programs. Response choices are listed below. Check all that apply.

Psychiatric Hospital: (Treatment_History_Psychiatric_Hosp) Indicate whether the member has received psychiatric hospital inpatient service.

Partial Hospitalization: (Treatment_History_Partial_Hosp) Indicate if the member has received psychiatric partial hospitalization services.

Crisis Stabilization or Crisis Support: (Treatment_History_Crisis_Stab _Support) Indicate if the member has received crisis stabilization for mental health or substance abuse conditions (this includes detoxification) or crisis support services.

Substance Abuse: (Treatment_History_SA_Outpatient) Indicate if the member has received substance abuse outpatient services.

Substance Abuse Inpatient: (Treatment_History_SA_Inpatient) Indicate whether the member has received substance abuse inpatient/residential services.

Psychiatric Residential Treatment Facility (PRTF): (Treatment_Hx_PRTF) Indicate whether the member has received PRTF services.

Intensive Outpatient Services: (Treatment_Hx_IOP _Services) Indicate whether the member has received mental health and/or substance abuse intensive outpatient services.

Behavioral Health Residential Services: (Treatment_Hx_BH _Residential) Indicate whether the member has received behavioral health residential services.

GUARDIANSHIP INFORMATION

Guardianship Description: (Guardian_Description) Identify person(s) who has current legal custody of the member by selecting one of the following choices:

- **Both Parents**
- **Mother Only**
- **Father Only**
- **Relative**
- **Court Appointed Guardian**
- **Temporary State Custody – Youth**
- **State Ward – Youth Only**
- **Other**

Guardian's Last Name: (Guardian_Last_Name) The last name of the member's current guardian is noted here. If both parents are guardians, choose one. If one parent is custodial, list the custodial parent.

Guardian's First Name: (Guardian_Firstname) The first name of the member's current guardian is indicated here.

Guardian's Full Street or P.O. Box Address: (Guardian_Address) Indicate the member's current guardian's full street or post office box address.

Guardian's City Address: (Guardian_City) Report the city in which the member's legal guardian resides.

Guardian's State Address: (Guardian_State) Note the 2-digit code representing the state in which the member's current guardian resides.

Guardian Zip Code: (Guardian_ZipCode) This is the guardian's zip code of his/her current residence. (Numeric 10 digits) If the +4 zip code is known, please include a hyphen after the first 5 digits and then code the +4.

Guardian's Phone Number: (Guardian_Phone_Number) List the telephone number (including area code) of the member's current guardian.

PROBLEM IDENTIFICATION

Primary Presenting Problem: (Primary_Presenting_Problem) Record the primary problem that is the major focus of treatment at this time. A member may seek services as a result of multiple problems; however, select the highest priority problem from the following list.

NOTE: If Other: Mental Health Problem or Other: Substance Abuse Problem is chosen, please include specific information in the free text field to further clarify the problem.

- **Abandonment**
- **Abuse: Physical, Psychological, and/or Sexual**
- **Acting Out: Aggression**
- **Acting Out: Sexual**
- **Behavioral Problems**
- **Catastrophic Loss (i.e., Theft, Flood, Fire)**
- **Change in Family Circumstances**
- **Criminal Charges: Drug Related**
- **Criminal Charges: other, Non-Drug Related**
- **Death/Bereavement**
- **Developmental Disability: Non-I/DD**
- **Divorce/ Marital Problems**
- **Fire Setting**
- **Housing**
- **Intellectual Disabilities**
- **Job /Loss of Job/ Work-Related problems**
- **Legal Reason/Problem**
- **Mental Illness**
- **Moved to New Residence**
- **Neglect**
- **Physical Health Problems: Non Substance Abuse Related**
- **Physical Health Problems: Substance Abuse Related**
- **Physical Disability/Handicap**
- **Pregnancy**
- **Relationship Problems**
- **School/Educational Problems**
- **Serious Illness Diagnosed**
- **Sibling Conflict**
- **Social Problems**
- **Substance Abuse: Drugs**
- **Substance Abuse: Alcohol**
- **Substance Abuse During Pregnancy**
- **Suicidal/Suicide Attempt**
- **Other: Mental Health Problem**
- **Other: Substance Abuse Problem**
- **No Additional presenting problem**
- **Co-Occurring Mental Illness and Substance Abuse**
- **Parent/Child Conflict**
- **Concern about Sexual Identity/ Orientation.**

The two (2) fields below are Presenting Problems 2 and 3 and may be used for reporting additional problems identified on the treatment plan. If there are no problems identified other than the primary presenting problem, the appropriate response to Presenting Problem 2 and Presenting Problem 3 is "No Additional Presenting Problem."

Present Problem 2: (Presenting_Problem2) If present, identify a secondary presenting problem from the list above.

Present Problem 3: (PROB3) If present, identify a tertiary presenting problem from the list above.

CLINICAL INFORMATION

Medical: Report general medical condition that is potentially relevant to understanding and/or managing the individual's mental disorder. You may include a text description or an ICD-10 code. It may be left blank if no relevant condition exists.

Additional Diagnosis: An additional diagnosis can be supplied here if the member has multiple diagnoses and you have already identified diagnoses in the earlier fields. Consider this diagnosis when selecting the disability group. If the member has no additional diagnoses indicate the code for no diagnosis.

MENTAL STATUS EXAMINATION

These items relate to the findings from the member's most recent mental status examination. Requested treatment interventions should take into account the member's current mental status.

Modifications to the standard examination have been made for evaluating children and specific mental status items have been developed for use with children. Items should also be modified in light of educational and environmental factors (e.g. adult in an impoverished environment who cannot name past presidents as part of general knowledge assessment does not have limitations based on failure to respond to that item alone).

Mental Status Orientation: Indicate Yes or No to the member's orientation to each of the following: time, person, place, and situation as noted in the most recent Mental Status Examination. Each item must be rated.

- **Person**
- **Place**
- **Time**
- **Situation**

Mental Status Speech: (Mental_Status_Speech) Indicate the element that best characterizes the member's speech at the time of the mental status exam.

- **Within Normal Limits (WNL)**
- **Blocked:** Involuntary cessation or interruption in speech (related to thought blocking) because of unconscious emotional factors
- **Incoherent:** Speech is unintelligible by the order of words strung together
- **Mutism:** The inability or unwillingness to speak
- **Pressured:** increase in the amount of spontaneous speech; loud or accelerated speech (rapid may also apply) as occurs in mania, schizophrenia or other organic disorders
- **Rapid:** Tendency to speak at a frenzied pace that is difficult to understand
- **Slurred:** Difficulty in articulating words due to lack of enunciation.
- **Stuttering:** sounds, syllables, or words are repeated or prolonged

Mental Status Appearance: (Mental_Status_Appearance) Indicate the element that best characterizes the member's appearance at the time of the mental status exam.

- **Within Normal Limits (WNL)**
- **Disheveled**
- **Bizarre**
- **Unkempt**

- **Meticulous**

Mental Status – Thought Content: (Mental_Status_Thought) Indicate the element that best characterizes the member's thought processes at the time of the mental status exam.

- **Within Normal Limits (WNL)**
- **Tangential:** Disturbance of thought whereby the ability to communicate a central idea is impaired and communication is oblique, digressive or irrelevant. The failure to communicate the idea differentiates tangentiality from circumstantiality, where the goal idea is communicated but in a delayed or indirect manner
- **Flight of Ideas:** Rapid succession of fragmentary thoughts in which content changes abruptly
- **Thought Blocking:** Involuntary cessation or interruption of thought processes because of unconscious emotional factors
- **Loose Association:** characteristic schizophrenic thinking involving a disorder in the logical progression of thoughts resulting in failure in communication because ideas are unrelated and unconnected and shift from one subject to another.
- **Perseveration:** Pathological repetition of the same response to different stimuli; persistent repetition of specific words or concepts
- **Conceptual Disorganization:** Expression of thoughts/ concepts is confused, disorganized or disconnected. Relevant concepts may be known to the client but the ability to appropriately apply concepts is disturbed and the client may not be able to distinguish various aspects of one concept from another. The result is inability to put a series of tasks in a logical sequence or to tie actions to an understanding of a concept.

Mental Status Sociability: (Mental_Status_Sociability) Indicate the element that best characterizes the member's sociability at the time of the mental status exam.

- **Isolation**
- **Uninhibited/Dis-inhibited**
- **Gregarious**
- **Inhibited**
- **Withdrawn**
- **Inappropriate**
- **Within Normal Limits**

Mental Status Recall/Memory: (Mental Status_Recall_Memory) Indicate any deficiency in one of the following areas:

- **Normal**
- **Short term/working memory**
- **Remote**

Mental Status Coping Ability: (Mental_Status_Coping_Ability) Indicate the element that best describes the member's coping ability:

- **Normal**
- **Resilient**
- **Deficient supports**
- **Deficient coping skills**
- **Exhausted**
- **Overwhelmed**
- **Improving**

Mental Status Affect: (Mental_Status_Affect) Indicate the element that best characterizes the member's affect.

- **Appropriate**
- **Blunted**
- **Labile**
- **Flat**
- **Broad**
- **Restricted**

MEDICATION AREA

Medication: Indicate if the member is currently on any psychotropic medications. Indicate "Yes" or "No."

If this field is answered "No," specific medication fields, medication efficacy and medication compliance require no response.
If this field is answered "Yes," please indicate the psychotropic medication(s) the member is prescribed in the appropriate fields below. If a psychotropic is used for a purpose other than the one the category suggests (e.g. an anticonvulsant such as Neurontin is being used as an anti-anxiety agent), record the medication in the category in which it appears on the listings (e.g., not under anti-anxiety in the above example).

If multiple medications are prescribed in a given category and bear discussion, these can be discussed in the free text field.

Antidepressants: (Med_Antidepressant) Make a selection from the following list if the member's current medications include an antidepressant.

- **Amitriptyline (Elavil)**
- **Bupropion (Wellbutrin)**
- **Citalopram (Celexa)**
- **Clomipramine (Anafranil)**
- **Desipramine (Norpramin)**
- **Doxepin (Sinequan)**
- **Escitalopram (Lexapro)**
- **Fluoxetine (Prozac)**
- **Fluvoxamine (Luvox)**
- **Imipramine (Tofranil)**
- **Maprotiline (Ludiomil)**
- **Mirtazadine (Remeron)**
- **Nefazodone (Serzone)**
- **Nortriptyline (Pamelor)**
- **Paroxetine (Paxil)**
- **Phenelzine (Nardil)**
- **Protriptyline (Vivactil)**
- **Sertraline (Zoloft)**
- **Trazodone (Desyrel)**
- **Venlafaxine (Effexor)**
- **Desvenlafaxine (Pristiq)**
- **Duloxetine HCl (Cymbalta)**

Antidepressant (Other): (Med_Antidepressant_Other) Note the name of the antidepressant the member is prescribed if not listed above.

Anticholinergic: (Med_Anticholinergics) Make a selection from the following list if the member's current medications include an anticholinergic.

- **Amantadine (Symmetrel)**
- **Benztropine (Cogentin)**
- **Diphenhydramine (Benadryl)**
- **Levodopa/Carbidopa (Sinemet)**
- **Trihexyphenidyl (Artane)**

Anticholinergic (Other): (Med_Anticholinergic_Other) Note the name of the anticholinergic the member is prescribed if not listed above.

MoodStabilizer: (MEDS_MoodStabilizer) Make a selection from the following list if the member's current medications include a mood stabilizer.

- **Carbamazepine (Tegretol)**
- **Divalproex (Depakote)**
- **Lithium (Eskalith)**
- **Propanolol (Inderal)–(Beta Blocker used for Aggression)**
- **Valproic Acid (Depakene)**

Mood Stabilizer (Other): (MEDS_Mood_Other) Note the name of the mood stabilizer the member is prescribed if not listed above.

Antipsychotic: (MEDS_AntiPsychotic) Make a selection from the following list if the member's current medications include an antipsychotic.

- **Aripiprazole (Abilify)**
- **Chlorpromazine (Thorazine)**
- **Clozapine (Clozaril)**
- **Fluphenazine (Prolixin)**
- **Haloperidol (Haldol)**
- **Loxapine (Loxitane)**
- **Mesoridazine (Serentil)**
- **Olanzapine (Zyprexa)**
- **Perphenazine (Trilafon)**
- **Quetiapine Fumarate (Seroquel)**
- **Risperidone (Risperdal)**
- **Thioridazine (Mellaril)**
- **Thiothixene (Navane)**
- **Trifluoperazine (Stelazine)**
- **Ziprasidone (Geodon)**
- **Paliperidone (Invega)**
- **Iloperidone (Fauapt)**
- **Asenapine (Saphris)**

AntiPsychotic (Other): (MEDS_Psychotic_Other) Note the name of the antipsychotic the member is prescribed if not listed above.

AntiAnxiety: (MEDS_Antianxiety) Make a selection from the following list if the member's current medications include an anti-anxiety medication.

- **Alprazolam (Xanax)**
- **Buspirone (Buspar)**
- **Chlordiazepoxide (Librium)**
- **Clonazepam (Klonopin)**
- **Clorazepate (Tranxene)**
- **Diazepam (Valium)**
- **Diphenhydramine (Benadryl)**
- **Hydroxyine (Vistaril)**
- **Lorazepam (Ativan)**
- **Oxazepam (Serax)**

AntiAnxiety (Other): (MEDS_Anxiety_Other) Note the name of the antianxiety medication the member is prescribed if not listed above.

Anticonvulsant: (MEDS_AntiConvulsant) Make a selection from the following list if the member's current medications include an anticonvulsant.

- **Carbamazepine (Tegretol)**
- **Divalproex (Depakote)**
- **Gabapentim (Neurontin)**
- **Levetiracetam (Keppra)**
- **Lamotrigine (Lamictal)**
- **Oxcarbazepine (Trileptal)**
- **Phenobarbital**
- **Phenytoin (Dilantin)**
- **Valproic Acid (Depakene)**
- **Topiramate (Topamax)**

AntiConvulsant (Other): (MEDS_Convulsant_Other) Note the name of the anticonvulsant the member is prescribed if not listed above.

Hypnotic: (MEDS_Hypnotic) Make a selection from the following list if the member's current medications include a hypnotic.

- **Estazolam (ProSom)**
- **Flurazepam (Dalmane)**
- **Pentobarbital (Nembutal)**
- **Temazepam (Restoril)**
- **Zolpidem (Ambien)**
- **Zaleplon (Sonata)**

Hypnotic (Other): (MEDS_Hypnotic_Other) Note the name of the hypnotic the member is prescribed if not listed above.

Stimulant: (MEDS_Stimulant) Make a selection from the following list if the member's current medications include a stimulant.

- **Adderall (Adderall)**
- **Atomoxetine (Strattera)**
- **Desmethylphenidate (Focalin)**
- **Dextroamphetamine (Dexedrine)**
- **Methylphenidate (Ritalin)**
- **Methylphenidate (Metadate)**
- **Methylphenidate (Methylin)**
- **Methylphenidate HCl (Concerta)**
- **Methamphetamine Hydrochloride (Desoxyn)**
- **Provigil (Modafinil)**
- **Guanfacine (Intuniv)**
- **Lisdexamfetamine (Vyvanse)**

Stimulant (Other): (MEDS_Stimulant_Other) Note the name of the stimulant the member is prescribed if not listed above.

Other: (MEDS_Other) Make a selection from the following list if the member's current medications are noted.

- **Buprenorphine Hydrochloride (Buprenex,**
- **Suboxone, Subutex)**
- **Clonodine (Catapres)**
- **Disulfiram (Antabuse)**
- **Donepezil (Aricept)**
- **Ergoloid Mesylate (Hydergine)**
- **Guanfacine HCl (Tenex)**
- **Hydroxine (Atarax)**
- **Methodone Hydrochloride (Methadose)**
- **Naltrexone Hydrochloride (ReVia)**
- **Rivastigmine (Exelon)**
- **Fluoxetine & Olanzapine (Symbyax)**
- **Tacrine (Cognex)**
- **L-methylfolate (Deplin)**
- **Acamprosate (Campral)**

MEDS – Other (Other): (MEDS_Other_Other) Note the name of other psychotropic medication (or medication for health related problems that may impact the efficacy or effects of psychotropic medications e.g. blood pressure medications) the member is prescribed if not listed above.

Over the counter medications and herbals are not listed here unless they are being monitored for possible interactions with prescribed medications.

Medication Efficacy - (Meds_Efficacy): Indicate the statement that most accurately reflects the member's response to the prescribed medication(s) (noted in the medication fields above):

- **Current medication protocol effectively reduces symptoms and aids in improvement in functioning**
- **Current medication protocol has demonstrated a degree of efficacy but continued monitoring and/or adjustments will be required**
- **Medication protocol is not effective and is being modified/discontinued by the physician**
- **Current medication protocol has not been implemented due to member non-compliance**

Medication Compliance - (Meds_Compliance): Select the statement that most accurately reflects the member's compliance with prescribed medications (noted in the medication fields above):

- **Member takes medication as directed without prompts or direct assistance (independent)**
- **Member takes medication with prompts and/or direct assistance from natural support systems (family, friends, peers)**

- **Member takes medication with prompts from the behavioral health provider**
- **Member takes medication with direct assistance from the behavioral health provider**
- **Member is non-compliant with the medication protocol.**

SYMPTOMATOLOGY SECTIONS

Operational definitions of most symptoms can be found in the DSM/ICD diagnostic criteria. For children the CAFAS Guidelines offer significant supplemental information related to many of these symptoms and how to evaluate them in children and youth. The intent of this section is to identify symptoms currently experienced by the member and an indication of how long this problem has affected the member.

In gathering history for members not previously known to a provider, the most complete and accurate data available at the time of the initial evaluation should be included. This information may be modified in subsequent admissions based on further information available from records or collateral sources.

SYMPTOM HISTORY

Symptom History fields describe a variety of symptoms that are grouped according to functional areas (e.g. Safety, Socialization, Thought, Affect, Energy and Somatic Concerns).

For each symptom listed in a category, indicate if the member has exhibited the symptom/behavior in the past six (6) months by choosing from the following list:

- **Symptom Never Present**
- **1 – 180 Days**

NOTE: *If endorsement of a symptom or a historical diagnosis is the basis for rating this item, please indicate this in the free-text field.*

Symptom History: Safety

These are symptoms that by history relate to the member's potential danger to self or others.

Suicidal History: (Safety_Suicidal_History) Suicidal history includes history of suicidal ideation and attempts.

Homicidal History: (Safety_Homicidal_History) Homicidal history includes history of homicidal ideation and attempts. Previous fleeting thoughts of wishing someone were not here with no overt thoughts are not rated as homicidal. Physical aggression is not considered homicidal unless the intention was to kill; acts of physical aggression are coded as violent history.

Hostile History: (Safety_Hostile_History) Hostility includes emotions and attitudes as well as overt violence. A history of hostile behavior includes a range of behaviors from frequent angry episodes (that includes yelling and screaming, threatening physical harm and may include slamming or throwing things) to severe hostility (which includes sustained verbal hostility which causes emotional harm to the victim) as well as, assault

or property damage with no harm. Hostility should be rated, as well as Violent, when there is a history of assault with physical harm and/or assault with a weapon.

Violent History: (Safety_Violent_History) Violent/Aggressive Behavior includes acts of physical aggression ranging from mild violence (which includes slapping, biting, and other physical acts which do not seriously harm the victim) to serious acts which cause physical harm. History of assault with a weapon or physical aggression which causes severe harm or death is rated here.

Self-Neglect History: (Safety_Self_Neglect_History) Self Neglect relates to personal hygiene and overall self-care including eating regularly and taking medications. This item should not be marked for individuals who are unable to attend to matters of personal hygiene and self-care due to their degree of mental retardation or developmental stage (e.g. child). For example, a person with moderate Intellectual Disability whose assessment reflects problems with feeding themselves or dressing, would not be listed as self-neglectful because they fail to perform these activities.

Self-Injurious History: (Safety_Self_Injurious_History) Self-injurious behaviors include non-accidental behaviors (such as pinching, scratching, biting that are not likely to cause serious harm), suicidal gestures, and self-mutilation or non-accidental behaviors that while not likely to cause serious harm are not trivial (e.g. razor cuts, refusal to eat). Self-injurious behavior also includes suicide attempts and intentional behaviors that could result in death (accidental drug overdose and DUI are not rated here). Self-injury resulting from an eating disorder can be coded here.

Symptom History: Thought

These are symptoms present by history that relate to disturbances of thought (psychosis). If these symptoms have occurred while the member is under the influence of substances or have occurred when the member is withdrawing from substances, this should be noted in the free text field and the appropriate substance abuse diagnosis included.

Hallucinations History: (Thought_Hallucinations_History) Hallucinations are defined as false sensory perceptions (visual, auditory, tactile or olfactory) occurring in the absence of any relevant external stimulation of the sensory modality involved. Hallucinations should be coded by history when documented and/or known to have affected the member's functioning.

Delusions History: (Thought_Delusions_History) Delusions are false beliefs that are firmly held, despite objective and obvious contradictory proof or evidence and despite the fact that other members of the culture do not share the belief. Delusions should be coded by history when documented and/or known to have affected the member's functioning.

Paranoia History: (Thought_Paranoia_History) Paranoia by history is marked by the presence of a complex delusional system generally involving persecutory or grandiose delusions with few other signs of personality disorganization or thought disorder. Paranoia should be coded by history when documented and/or known to have affected the member's functioning. Self-report by history, in the absence of any objective documentation, should not be used as the sole basis for including this symptom by history. Paranoid ideation (ideation of less than delusional proportions involving

suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated) should not be coded as paranoia history.

Symptom History: Socialization

These are symptoms/behaviors that relate to the member's ability to form and sustain relationships and their behavior toward others.

Oppositional Behavior History: (Socialization_Opp_Beh_History) Oppositional/Defiant Behavior is characterized by pervasive negativism, continuous argumentativeness and an unwillingness to comply with reasonable suggestions and persuasion. This is an established pattern of behaviors and is manifested in a variety of settings. Developmental and environmental factors must be taken into account when evaluating this behavior. For example, typically adolescents exhibit a degree of oppositional behavior. The behavior must be clinically significant and outside of age/developmental norms to be coded.

Symptom History: Affect, Emotive, Somatic Concerns

These are symptoms that by history relate to the member's moods and emotions, changes in energy level and ability to sustain activities of daily living and somatic concerns.

Depression History: (AES_Depression_History) Depression by history refers to a prolonged period of depressed mood or a mood disorder characterized as depressive. Rating this symptom as present by history indicates a behavioral health disorder in the mood and affective realm should be present and that other symptoms relevant to mood disorders characterized as depressive are also present.

Anxiety History: (AES_Anxiety_History) Anxiety is an emotional state associated with psychophysiological changes in response to an intrapsychic conflict. In contrast to fear, the danger or threat in anxiety is perceived not real. Psychological changes consist of a feeling of impending danger, inability to perceive the unreality of the threat, prolonged feeling of tension, and exhaustive readiness for the perceived danger; Physiological changes include increased heart rate, disturbed breathing, trembling, sweating, and vasomotor changes. If diagnosis by history is the criteria for rating this item as present, the length of time since the diagnosis was rendered should be reported. Worries about family issues, finances or other real issues should not be the basis for a positive rating for this symptom unless judgment or functioning has been impaired (e.g. inability to perceive the link between excessive spending and financial problems or contemplating suicide to escape financial problems).

Compulsions are unwanted, repetitive urges to perform an act and failure to perform the act leads to overt anxiety. An obsession is a persistent and recurrent idea, thought or impulse that cannot be eliminated from consciousness by logic and reasoning and often leads to overt anxiety. When obsessions and/or compulsions are present, or Obsessive Compulsive Disorder has been diagnosed, rate the presence of the symptom cluster of obsessions, compulsion and anxiety in this item.

Panic History: (AES_Panic_History) Panic is an acute, intense attack of anxiety associated with personality disorganization; the anxiety is overwhelming and impacts functioning. This symptom is associated with diagnoses of Panic Disorder, Post-

Traumatic Stress Disorder, Schizophrenia, Major Depression, and Somatization Disorder.

Phobic History: (AES_Phobic_History) Phobias are persistent, pathological, unrealistic, intense fear of an object or situation. The person may be aware that the fear is irrational but be unable to dispel it. If phobias are the focus of treatment the impact on functioning must be demonstrated as part of establishing medical necessity for treatment.

Manic/Hypomania History: (AES_Mania_History) Mania is a mood disorder characterized by elation, agitation, hyperactivity and hyper-excitability, and accelerated thinking and speaking (flight of ideas). This mood state characterizes the manic phase of bipolar disorder. Hypomania is a mood with the qualitative characteristics of mania but with less intensity.

Mania may present differently in children and adolescents than it does in adults. For example, symptom fluctuation may be more rapid and symptoms may include intense emotionality, mood swings, less need for sleep, and increased physical activity and frequency in talking.

Hyperactivity History: (AES_Hyperactivity_History) This symptom is manifested by excessive motor activity, constant restlessness, over activity, distractibility, and attention difficulties that are present to a degree that interferes with learning and/or overall functioning. This symptom is most often related to Attention Deficit Disorder.

SYMPTOM ACUITY

These items describe a variety of symptoms that are grouped according to functional areas (Safety, Socialization, Thought, Affect, Energy and Somatic Concerns, and Other Symptoms). For each symptom listed in a category, indicate the level of severity based on frequency, longevity, and level of impairment caused by the symptom through the following choices:

- **Not Present**
- **Mild**
- **Moderate**
- **Severe**
- **Acute/Crisis**

NOTE: Code "Not Present" if the symptom/behavior is not currently present even if the member has exhibited the symptom/behavior by history.

It is expected that the individual gathering information regarding a member's symptom acuity has training and experience with clinical interviewing, the DSM-IV-TR, rendering diagnosis or diagnostic impression, conducting a mental status examination and developing appropriate treatment plans. In instances where the symptom acuity is reported for a new admission, the information should represent the best available information from client report, collateral interviews and reports.

The member's age, developmental level, environmental factors, and substance use/abuse problems play a significant role in evaluating symptoms. For individuals with substance abuse/use, if a symptom rating is based on evaluation while the member is intoxicated this should be reflected in the diagnosis and noted in the free text field (ex. hallucinations while under the influence of a hallucinogen).

SAFETY

These recent symptoms relate to the member's potential danger to self or others.

Suicidal Acuity: (Safety_suicidal_acuity) Rate this item relative to the degree suicidal behavior (gestures or attempts) or ideation is present. Infrequent suicidal ideation would be rated mild whereas a suicide attempt(s) would be rated severe. Occasional thoughts of being tired of living with no overt suicidal thoughts are not rated as suicidal. If a suicide attempt has prompted the request for service/change in treatment plan, Acute/Crisis should be indicated.

Homicidal Acuity: (Safety_Homicidal_acuity) Ideations are rated as mild to moderate and overt actions/attempts are rated as moderate/severe depending on the nature of the behavior. If Homicidal behavior has prompted the request for service/change in treatment plan, Acute/Crisis should be indicated. Fleeting thoughts of wishing someone were not here with no overt homicidal thoughts are not rated as homicidal.

Risk Assessment: Depending upon the responses to suicidal and homicidal fields in the current acuity, the user **may** be required to complete the following data elements relate to intent, means and plan for harming self or others.

Risk to Self: (Risk_Risk_to_Self)

- **None**
- **Ideation only**
- **Ideation with plan**
- **Ideation with means**
- **Ideation with attempt(s) in last year**
- **Ideation with prior attempts > 1 year**
- **Ideation with family/peer history**
- **Ideation with previous attempts and family/peer history**
- **Plan**
- **Plan with attempt(s) in last year**
- **Plan with attempts > 1 year**
- **Plan with family/peer history**
- **Plan with previous attempts and family/peer history**
- **Means**
- **Means with attempt(s) in last year**
- **Means with attempts > 1 year**
- **Means with family/peer history**
- **Means with attempts and family/peer history**
- **Assessed lethality warrants inpatient hospitalization**
- **Plan and means**
- **Plan and means with attempt(s) in last year**
- **Plan and means with attempts > 1 year**
- **Plan and means with family/peer history**
- **Plan and means with attempts and family/peer history**

Risk to Others: (Risk_Risk_to_Others)

- **None**
- **Ideation only**
- **Ideation with plan**
- **Ideation with means**

- **Ideation with plan and means**
- **Ideation with prior attempts**
- **Ideation with plan, means and prior attempts**
- **Plan**
- **Plan with means**
- **Plan with means and prior attempts**
- **Plan with prior attempts**
- **Means with prior attempts**
- **Assessed lethality warrants inpatient hospitalization**

Contracted Not to Harm: (Risk_No_Harm_Contract)
- **Declined/Not Offered (Provider does not use)**
- **Self**
- **Others**
- **Self/Others**

Prior History: Has the member experienced any of the following:
- **Physical /sexual abuse victim**
- **Physical/sexual abuse perpetrator**
- **Bulimia**
- **Anorexia**
- **Child/Elder Neglect**
- **None**

Hostile Acuity: (Safety_Hostile_acuity) Hostility includes emotions and attitudes as well as overt violence. Rating is mild when history includes angry episodes that include yelling and screaming, threatening physical harm and may include slamming or throwing things. Severe includes sustained verbal hostility that causes emotional harm to the victim as well as assault or property damage with no harm. Crisis/acute includes assault with physical harm and/or assault with a weapon.

Violent Acuity: (Safety_violent_acuity) Violent/Aggressive Behavior includes acts of physical aggression. Mild violence includes slapping, biting and other physical acts which do not seriously harm the victim; severe includes acts which cause physical harm. Assault with a weapon or physical aggression that causes severe harm or death is rated as acute/crisis.

Self-Neglect Acuity: (Safety_self_neglect_acuity) Self Neglect relates to personal hygiene and overall self-care including eating regularly and taking medications. A mild rating for this item indicates that hygiene is below acceptable standards and likely to draw some comment. A severe rating indicates that hygiene is erratic and poor. This includes extreme body odor, unkempt and dirty clothing and refusal to attend to personal hygiene and self-care unless prompted. This item should not be marked for individuals who have intellectual disabilities and are unable to attend to matters of personal hygiene and self-care.

A severe rating indicates that self-neglect has contributed to adverse physical (health), emotional (symptoms have increased) or functional consequences (functioning has decreased).

Self-Injurious Acuity: (Safety_self_injurious_acuity) Self-Injury includes non-accidental behaviors that cause physical harm and/or interfere with functioning.

Mild self-injurious behaviors include non-accidental behaviors such as pinching, scratching, and biting that are not likely to cause serious harm. Moderate self-injurious behavior includes suicidal gestures, self-mutilation or non-accidental behaviors that, while not likely to cause serious harm, are not trivial (e.g. razor cuts, refusal to eat). Severe self-injurious behavior includes suicide attempts and intentional behaviors that could result in death (accidental drug overdose and DUI are not rated here). Acute/Crisis rating includes suicide attempts that nearly result in death and, risk of death due to the progression of an eating disorder. Self-injury resulting from an eating disorder can be coded here.

THOUGHT

These are recent symptoms that relate to disturbances of thought (psychosis). If these symptoms have occurred while the member is under the influence of substances or have occurred when the member is withdrawing from substances, this should be noted in the free text field and the appropriate substance abuse diagnosis is included.

Hallucinations Acuity: (Thought_hallucinations_acuity) Hallucinations are defined as false sensory perceptions not associated with real external stimuli of the sensory modality involved. All types of hallucinations are evaluated here but the specific sensory modality(ies) may be indicated in the free text field (e.g. visual, gustatory etc.). Hallucinations are considered a significant symptom and should be coded from mild to severe based on the frequency, longevity, and level of impairment caused by the symptom.

Delusions Acuity: (Thought_Delusions_acuity) Delusions are false beliefs that are firmly held, despite objective and obvious contradictory proof or evidence and despite the fact that other members of the culture do not share the belief. Delusions should be coded from mild to severe based on the frequency, longevity, and level of functional impairment caused by the symptom.

Paranoia Acuity: (Thought_Paranoia_acuity) Paranoia is marked by the presence of a complex delusional system, generally involving persecutory or grandiose delusions with few other signs of personality disorganization or thought disorder. Paranoia should be coded when documented and/or known to have affected the member's functioning. Paranoid ideation (ideation of less than delusional proportions involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated) should not be coded except as mild. This symptom should be coded from mild to severe based on the intensity of the symptom and the level of functional impairment associated with the presence of the symptom.

Poor Concentration Acuity: (Thought_poor_concentration_acuity) Poor concentration is characterized by inability to pay exclusive attention to one object, not making close mental application or not focusing one's attention on one thing. (This differs from distractibility in that a person who is experiencing distractibility can focus on one thing briefly, but jumps from thing to thing) This symptom is not clinically significant when the inattention is a result of lack of interest in situations where failure to complete an activity does not have adverse consequences (e.g. failure to complete a leisure activity as opposed to failure to complete assignments at work or school).

This symptom is most frequently associated with Attention Deficit Disorders, although persons with Depression and Anxiety Disorders may also often exhibit this symptom.

Poor concentration should be coded from mild to severe based on the frequency, longevity, and level of impairment and consequences caused by the symptom. This symptom is also frequently noted in early recovery from Substance Abuse/Dependence.

Suspiciousness Acuity: (Thought_suspiciousness_acuity) Suspiciousness is a clinically significant symptom when the level of mistrust or uncertainty exhibited is incongruent with fact or is not associated with actual events or experiences. This symptom is most often associated with Paranoid Schizophrenia and Paranoid Personality Disorder.

Suspiciousness should be coded from mild to severe based on the frequency, longevity, level of impairment, and impact on activities and relationships caused by the symptom.

Circumstantial Thinking: (Thought_Circumstantial_Thinking) Disturbance in thought characterized by communication of unnecessary details before conveying the central idea. Typically associated with Schizophrenia and some cases of Dementia.

Obsessions/Intrusive Thoughts: (Thought_Obsessions_Intrusive _Thoughts) An obsession is a persistent and recurrent idea, thought or impulse that cannot be eliminated from consciousness by logic and reasoning and often leads to overt anxiety. When obsessions and/ or compulsions are present or Obsessive Compulsive Disorder has been diagnosed, rate the severity of the symptom or symptom cluster and the degree to which the symptom interferes with normal functioning.

SOCIALIZATION

These symptoms/behaviors relate to the member's ability to form and sustain relationships and their behavior toward others.

Oppositional Behavior Acuity: (Socialization_Opp_behavior_acuity)
Oppositional/Defiant Behavior is characterized by continuous argumentativeness, pervasive negativism, and an unwillingness to comply with reasonable suggestions and persuasion. This is an established pattern of behaviors and is manifested in a variety of settings. Developmental and environmental factors must be taken into account when evaluating this behavior.

Mild oppositional behavior results in impacted personal relationships particularly with authority figures; severe oppositional defiant behavior may impair the individual's ability to function in age appropriate settings (e.g., may result in school suspensions, out of home placement, multiple failed placements). This symptom is most often associated with Behavioral Disorders, particularly Oppositional Defiant Disorder and Conduct Disorders.

Withdrawal/Isolating Acuity: (Socialization_Withdrawal_acuity) This symptom is characterized by pathological retreat from interpersonal contact and social involvement and/or an extreme decrease of intellectual and emotional interest in the environment. This symptom is most often associated with Schizophrenia, Depression and Substance-Related Disorders.

The key to evaluating this symptom is the level of change from previous interaction that was normal for the individual. Using previous levels of interaction as the baseline for

evaluating the severity of the symptom provides an anchor that takes into account personality differences, interpersonal styles and levels of desired social involvement.

Impulsivity Acuity: (Socialization_Impulsivity_acuity) This symptom is characterized by weak impulse control resulting in impulsive behavior that is irresistible, pleasurable, and aimed at obtaining immediate gratification, without regard to possible consequences of the behavior.

Behaviors such as kleptomania, pyromania, explosive aggressive behavior would be rated as severe. A mild to moderate rating is warranted when there is a pattern of failure to meet responsibilities in order to perform activities perceived as more desirable. The rating is affected by the impact of the impulsivity on functioning, the greater the impact on functioning, the greater the rating of severity.

In instances of obsessive compulsive behavior where the impulse to perform compulsive behaviors or rituals is strong and the behaviors are interfering with functioning (e.g. time spent performing rituals severely impacts ability to perform ADL's) this symptom should be rated as positive and the severity linked to the degree of impact the obsessive compulsive behaviors have on functioning.

Evaluation of this symptom is critical for persons with Substance-Related Disorders. This symptom and poor judgment correlate to the DSM definition of loss of control. Persons with diagnoses of Substance Dependence may be rated moderate or above for this symptom.

Bizarre Behavior Acuity: (Socialization_Bizarre_Behavior_acuity) This symptom is rated as present when odd or eccentric behavior is present that relates to the diagnosed behavioral health condition. The severity rating is based on the impact the bizarre behavior is having on functioning and relationships. This symptom is most often related to Schizophrenia and other psychotic disorders.

Verbal Aggression: (Socialization_Verbal_Aggression) Communication is intended to cause perceived psychological pain in another person. Rating this item should consider frequency and severity of behavior.

Physical Aggression: (Socialization_Physical_Aggression) Behavior is directed to physically harm another person or item. Rating this item should consider severity and frequency of this behavior.

Compulsions: (Socialization_Complusion) Compulsions are unwanted, repetitive urges to perform an act and failure to perform the act leads to overt anxiety. Consider the frequency and degree of impact on functioning when rating this item.

Sexual Acting Out: (Socialization_Sexually_Acting_Out) Sexual behavior inappropriate for age, developmental level, socialization and/or circumstance directed toward others that encompasses predatory, manipulative and coercive behaviors.

Sexually Reactive Behavior: (Socialization_Sexually_Reactive) Sexual behavior exhibited by the member inconsistent with age, developmental level, socialization, and/or circumstance that are secondary to known or suspected sexual abuse and/or exposure.

AFFECT, ENERGY AND SOMATIC CONCERNS

These recent symptoms relate to the member's moods and emotions, changes in energy level and ability to sustain activities of daily living, and somatic concerns.

Depression Acuity: (AES_Depression_Acuity) Depression refers to a prolonged period of depressed mood or a mood disorder characterized as depressive. Depression is characterized by feelings of sadness, loneliness, despair, low self-esteem, apathy, withdrawal, psychomotor agitation or retardation and vegetative signs such as sleep or eating problems.

Rating this symptom as present indicates a behavioral health disorder in the mood and affective realm should be present (or under evaluation) and that other symptoms relevant to mood disorders characterized as depressive are also present (e.g. weight/appetite change, energy level changes, change in sleep patterns, lethargy, apathy, loss of interest in activities, etc.) and have been noted. The degree to which the depressive symptoms have been present and have impaired functioning is the basis of the rating.

Guilt Acuity: (AES_Guilt_Acuity) Guilt is most often associated with self-reproach and the need for punishment. Guilt has normal psychological and social functions and this symptom should only be marked when the intensity or absence of guilt is interfering with the client's ability to function as with many behavioral health disorders especially, Depression (high intensity) and Antisocial Personality Disorder (absence of guilt). Rating this symptom as present indicates that guilt is a symptom that has been directly impacting functioning.

Anxiety Acuity: (AES_Anxiety_Acuity) Anxiety is an emotional state associated with psychophysiological changes in response to an intrapsychic conflict. In contrast to fear, the danger or threat in anxiety is perceived not real. Psychological changes consist of a feeling of impending danger, inability to perceive the unreality of the threat, prolonged feeling of tension, and exhaustive readiness for the perceived danger. Physiological changes include increased heart rate, disturbed breathing, trembling, sweating and vasomotor changes. This symptom is most prominent in Anxiety Disorders (including Phobias), Panic Disorders, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, and Post-Traumatic Stress Disorder.

If the symptom is present, the intensity is based on the impact the symptom has had on functioning. Worries about family issues, finance or other real issues should not be the basis for a positive rating for this symptom unless the level of anxiety related to these concerns is disproportionate relative to the real threat (clinically significant) and is significantly impacting functioning.

Hopelessness/ Helplessness Acuity: (AES_Hope_helplessness_Acuity) This item refers to a high level or degree of anxiety or apathy about one's current situation and/or the future and a sense of negativism or lack of control over one's circumstances or situation. The individual perceives an inability to make decisions that can impact or improve their situation and has a sense that the outcome is inevitable despite actions on their part. This item should be anchored based on the person's history and their description of changes in their sense of control and anxiety or apathy about current circumstances or the future.

This item is most often present with other symptoms such as depression, anxiety, apathy, low energy and loss of interest in activities and may be a significant symptom when suicidal ideation or attempts are present. This symptom is frequently present with substance abuse/dependence conditions.

Apathy Acuity: (AES_Apathy_Acuity) Apathy is a lack of feeling or affect accompanied by a lack of interest and emotional involvement in one's surroundings. This item should be anchored based on the person's history of involvement and interest in activities and their surroundings. This item is most often present and clinically significant in diagnoses of Depression, Schizophrenia and Substance Dependence. This item is most often present with other symptoms such as depression, anxiety, blunted affect and/or hopelessness/helplessness.

Panic Acuity: (AES_Panic_Acuity) Panic is characterized by acute, intense attacks of anxiety; the anxiety is overwhelming, and is accompanied by feelings of impending doom. This symptom is rated based on the intensity of the panic and the impact on personality organization, functioning and relationships. This symptom is frequently present in Anxiety Disorders, Phobic Disorders and is the characterizing symptom in Panic Disorders.

Phobic Acuity: (AES_Phobic_Acuity) This symptom is present when the individual has a persistent, pathological, unrealistic, intense fear of an object or situation. Although the individual may realize that the fear is irrational, they are unable to dispel it. The rating for this symptom is dependent on the degree to which the symptom interferes with the individual's ability to function and perform activities of daily living.

Manic/Hypomania Acuity: (AES_Manic_Acuity) Mania is a mood disorder characterized by elation, agitation, hyperactivity and hyperexcitability, and accelerated thinking and speaking (flight of ideas). This mood state characterizes the manic phase of bipolar disorder.

Hypomania is a mood with the qualitative characteristics of mania but with less intensity. This symptom is rated based on the intensity of the mania, the degree to which it is interfering with rational behavior and the impact on functioning. This symptom is most often associated with Mood or Bipolar Disorder.

Mania may present differently in children and adolescents than it does in adults. For example, symptom fluctuation may be more rapid and symptoms may include intense emotionality, mood swings, less need for sleep, and increased physical activity and frequency in talking than is normal for the individual.

Agitation Acuity: (AES_Agitation_Acuity) Agitation is a state of anxiety associated with severe motor restlessness. This symptom should be distinguished from hyperactivity but may be related to anxiety, restlessness, high energy and distractibility. This symptom is rated on the degree of agitation and its impact on functioning, communication, and ability to perform activities of daily living. This symptom is frequently present in members withdrawing from substances and/or in early stages of recovery.

Change in Energy Acuity: (AES_Hi_Lo_energy_Acuity) This rating is based on the individual's report of changes in energy level, either increased or decreased energy. The rating should be made from baseline reports related to previous activity and energy. This

item should be distinguished from agitation, hyperactivity, and changes in energy level associated with mania. This item is most often linked to Depression, Mood, and Bipolar Disorders. This symptom is frequently present in members withdrawing from substances and/or in early stages of recovery.

Hyperactivity Acuity: (AES_Hyperactivity_Acuity) This symptom is manifested by excessive motor activity, constant restlessness, over-activity, distractibility and attentional difficulties that are present to a degree that they interfere with learning and/or overall functioning. This symptom is most often related to Attention Deficit Disorder. Symptom severity is rated based on the degree to which the symptom is interfering with age-appropriate functioning and the ability to perform activities of daily living. Collateral reports are helpful in determining the longevity and severity of this symptom.

Distractibility Acuity: (AES_Distractability_Acuity) Distractibility is the inability to focus attention for more than a brief period. The individual does not respond to the task at hand but attends to irrelevant elements in the environment or internal stimuli. This item is not rated positive if the failure to attend to the task at hand is an intentional effort to avoid responding to questions or to avoid confrontation or consequences. It is also not rated as positive if the inattention is the result of lack of orientation to person, place, time or situation or other disturbances of thought. The rating is based on the difficulty in focusing attention. This symptom is most often associated with Attention-Deficit Disorder, Anxiety, and Depression.
This symptom is frequently present in members withdrawing from substances and/or in early stages of recovery. If the level of distractibility is clinically significant after early recovery, another behavioral health condition may be present.

Weight Change/Appetite Acuity: (AES_Weight_Change) This item relates to loss or gain in weight and appetite increase or loss most often associated with depression. Severity of the symptom should be based on the severity of the weight loss/gain and potential impact on health. Extreme weight loss related to eating disorders may be rated as severe or acute/crisis if health is endangered and body image is skewed to the degree that the patient does not recognize the potential health threat. This symptom is also frequently present with Substance Dependence and Withdrawal.

Change in Sleep Patterns Acuity: (AES_Sleep_Change) This item relates to disturbances of sleep that are not medically based and are linked to other symptoms related to a behavioral health condition, particularly Depression. This item is evaluated in terms of baseline sleep patterns described by the individual and changes/ disruptions in these normal patterns. This symptom is also frequently present with Substance Dependence and Withdrawal.

AES Loss Interest Activities Acuity: (AES_Loss_interest_activities_Acu) This symptom relates to the individual's loss of interest in activities previously viewed as pleasurable or necessary. Anhedonia (inability to experience pleasure) should be evaluated here. This symptom is most frequently linked to other symptoms related to a behavioral health condition, particularly Depression. This item is evaluated in terms of baseline activity level and patterns described by the individual and changes/disruptions in these normal levels/patterns of activity. This symptom is frequently present in persons with substance dependence diagnoses.

Motivation/Engagement Acuity: (Treatement_Motivation_Acuity) Address the level of motivation for current treatment services. Treatment readiness and the member's

level of acceptance and resistance should be considered for rating this item. This item relates to motivation/engagement for any behavioral health service.

SUBSTANCE USE / ABUSE

These items are specific to substance use/abuse and to the member's motivation to seek and maintain treatment. The provider is also asked to evaluate the member's risk of withdrawal and relapse. If the symptom is present, indicate the level of symptom/behavior severity the member has exhibited.

Current Use of Substances: (SA_Current_Use_Substance): Identify if the member is currently using mood altering substances. A substance abuse or dependence diagnosis may not be present to endorse this item.

This item relates to the current level of substance use the client is exhibiting. This rating should be based on the clinician's analysis of the current symptoms and functioning, including results of the CAFAS *or* ASI, as well as the results of collateral interviews and other relevant information regarding the client's current level of substance use. Current tolerance is evaluated when rating this item.

History of Substance Use: (SA_History_Substance_Use) Identify whether the member has a history of using substances. A substance abuse or dependence diagnosis need not be present to endorse this item.

Type of Substance Used: Select all substances the member identifies as either currently using or has used in the past.

- **Cannabis (SA_Use_Cannabis)**
- **CNS Depressants (SA_Use_CNS_Depressants**
- **Alcohol (SA_Use_Alcohol)**
- **Stimulants (SA_Use_Stimulants)**
- **Opioid and Morphine Derivatives (SA_Use_Opioid_Morphine_Derivatives)**
- **Hallucinogens (SA_Use_Hallucinogens)**
- **Other (SA_Use_Other_Substance)**

Frequency of Use: (SA_Frequency_Use) Identify the rate of substance usage by the member. Periodic use refers to sporadic or occasional use. Binge Use refers to consuming large amounts of a substance within a single session/episode.

Date of Last Substance Use: (SA_Date_Last_Use) Identify the date the member indicates as the last use of substances.

Withdrawal Potential: (SA_Withdrawal_Potential) Indicate whether the member is at current risk for substance related withdrawal symptoms.

Relapse Potential Acuity: (Relapse_Potential_Acuity) Indicate the current potential for relapse for members with substance abuse/dependence diagnoses. Consider factors related to the clinician's analysis of the current level of denial, participation in treatment, symptoms and functioning (including results of the ASI) as well as the results of collateral interviews and other relevant information regarding the client's current level of substance use and progress in recovery. Cravings, physical conditions (i.e. pain), social network and supports and stress level should be evaluated when rating this item.

- **Low Risk of Relapse**

- **High Risk of Relapse**

LEVEL OF FUNCTIONING

These items relate to the member's level of functioning and ability to perform activities of daily living. Indicate the member's level of functioning using the following choices:

- **Not Applicable**: Individual has no history of a functional deficit in this area. If a member's age or functional level precludes the expectation to perform activities choose this response (e.g. access to other services for a five year old or person with the diagnosis of profound mental retardation).

- **No Impairment/Independent:** Individual had difficulties performing an activity in the past but currently does not require any type of assistance.

- **With Limited Impairment**: The individual requires intermittent assistance to perform the activity. Member is able to perform the activity with minimal reminders and without constant oversight.

- **With Significant Impairment**: The individual requires ongoing supervision and assistance in order to perform the activity and without this supervision is unable to complete the activity**.**

Functional impairments are evaluated relevant to the identified behavioral condition, symptoms, and history. They should be noted only once by choosing the item that best characterizes the deficit area (e.g. employment problems would be rated in School/Work and not included again in Activities of Daily Living). Impairments should be identified as a focus in treatment planning when the behavioral health condition (symptoms, level of clinical stability) directly influences the member's ability to function in these areas or to perform activities that they were previously able to perform.

Functional items should also be evaluated based upon appropriate age and developmental expectations. A member may not be expected to perform all activities within a functional area, only those that are age appropriate. For example, when evaluating a five year old relevant to Activities of Daily Living, make the rating based on age-appropriate activities of daily living for a five year old, such as dressing, brushing teeth, walking, feeding self etc. and the degree of assistance required to perform these tasks. Do not take into account activities the child would not be expected to perform independently such as caring for living space, shopping, finances, etc.

Functional Status School/Work: (Functional_Status_School) Indicate the level of impairment experienced by the child related to school attendance, demonstrating appropriate behaviors, and self-management skills in the school environment. For adults not in school, indicate the level of the adult's functioning related to performing work-related functions.

Functional Status for Activities of Daily Living: (Functional_Status_DayLive) Indicate the member's level of functioning related to performing activities of daily living. These activities include hygiene and grooming, maintaining a healthy diet, organizing and carrying out daily routines and activities, ambulation, performing household chores, caring for living space, managing finances, shopping, preparing or obtaining meals or other activities of daily living that are age and functionally appropriate.

Functional Status ADL Impairment: Identify areas of Activities of Daily Living impairment:

- **Nutritional Awareness (Functional_ADL_Nutritional_Aware)**
- **Meal Preparation and Clean Up (Functional_ADL_Meal_Prep_Cleanup)**
- **Personal Hygiene (Functional_ADL_ Personal_Hygiene)**
- **Childcare/Parenting (Functional_ADL_Childcare_Parenting)**
- **Household tasks/care for living space (Functional_ADL_Household_Tasks)**
- **Treat Minor Physical Problems (i.e., minor cuts, headache) (Functional_ADL_Minor_Physical_Problems)**

Functional Status Maintains Relationship: (Functional_Status_maintains_rela) Indicate the member's level of functioning related to maintaining interpersonal relationships. This item includes ability to communicate clearly, reflect wants and needs, form and maintain a social network, engage in social activities, maintain relationships with family or significant others, handle conflict, demonstrate appropriate assertiveness and request help when needed.

Functional Status Interacts Appropriately in Social Situations: (Functional_Social_Situations) Indicate the level of impairment experienced by the member related to functioning in social situations. This item includes comfort in social situations, being aware of spatial boundaries with others and reading social cues.

Functional Status Personal Safety: (Functional_Status_Pers_Safety) Indicate the member's level of impairment related to maintaining personal and community safety. This item relates to the ability to recognize and avoid common dangers (traffic, fire, etc.), respond appropriately in emergency situations (fire, etc.) and obtain assistance in an emergency.

This item also relates to engaging in dangerous behavior that places personal or community health or safety at risk, despite knowledge of the hazards of such behavior (e.g. mixing alcohol with prescription medications where contraindicated, runaway behavior, threatening others etc.). This also includes failure to take necessary medications for health conditions (e.g. hypertension, insulin) due to substance abuse or behavioral health symptoms.

Functional Status Accesses Other Services: (Functional_Status_accesses_other) Indicate the member's level of impairment related to accessing other services (transportation, recreation, etc.). This item also relates to arranging transportation to appointments and activities, ability to travel to and from residence as needed, accessing cultural, social and recreational opportunities and other community services such as shopping, banking, restaurants, medical services, etc.

TREATMENT PLAN

These items allow the choice of additional problem areas that best describe problems addressed on the member's current individualized treatment plan.

- **Physical Health**
- **Psychological Distress**
- **Psychiatric Symptoms**
- **Substance Abuse Behaviors**
- **Maladaptive/Antisocial Behaviors**
- **Self-injurious/Suicidal Behaviors**
- **Interpersonal Relations**
- **ADL Skill Building**
- **Maintaining ADL**

- **No Additional Problem/Focus Area**
- **Co-occurring MI/SA Symptoms**

Up to two (2) additional problem areas can be coded. If there are no additional problems to the primary treatment focus already entered, code No Additional Problems/Focus Area in the two fields. The problem areas identified should correlate with the presenting problems identified and the symptoms and functional impairments that are most prominent. Specific goals and objectives on the member's treatment plan should relate to the areas and needs identified in the Behavioral Health CareConnection® data.

Treatment Plan Summary 2: (Treatment_Plan_Summary2) Indicate the secondary problem that is addressed on the member's individualized treatment plan. If there is no secondary problem, code No Additional Problems/Focus Area.

Treatment Plan Summary 3: (Treatment_Plan_Summary3) Indicate the tertiary problem that is addressed on the member's individualized treatment plan. If there is no tertiary problem, code No Additional Problems/Focus Area.

Treatment Plan Summary Other: (Treatment_Plan_Summary_Other) Indicate any significant clinical issues being addressed in treatment that are not reflected in the information presented in this data set. Include justification of treatment needs to maintain functioning/symptom reduction if the member is currently functioning well and/or is asymptomatic.

Example: A member with a diagnosis of Schizophrenia who has been receiving services for two years is responding well to Clozaril, but requires continued medication maintenance. Symptom history on this form reflects numerous symptoms previously but symptom acuity reflects no current symptomatology and level of functioning indicates the need for direct assistance with several activities of daily living.

In this case, the current stability and responsiveness to Clozaril should be noted as justification for continued Medication Management. Any additional services required to maintain the member's current level of functioning should be noted with a brief justification for each.

This field is also utilized to communicate additional information related to specific fields (e.g. dates of inpatient hospitalization when requesting ACT service); denote atypical clinical presentations; list Rule Out diagnoses; indicate that a critical treatment juncture has occurred; or indicate the need for specific services and units approved as part of an Intensive Outpatient Program.

This notation will assist the care manager in making a determination on case status if the request pends, possibly for authorization without contact with the provider.

NOTE: This field may be left blank.

Level of Support: (Support_Family_Friends) Identify sources of support the member may utilize in addition to the treatment services being received.

- **Family/friends (Support_Family_Friends)**
- **Self-help Network (Support_Self_Help)**
- **Peer-oriented Services (Support_Peer_Oriented_Services)**
- **Recreation/Community Activities (Support_Rec_Community_Activities)**

- **Other Supports (Support_Other)**
- **None (Support_None)**

This completes the Outpatient/Tier 2 data elements.

DISCHARGE DATA ELEMENTS

The following elements should be completed when you are discharging a member from all services received from your organization.

The following are standard identification elements:

- **Member name**
- **Member ID number**
- **Provider Name**
- **Medicaid Member number**
- **Behavioral Health CareConnection® Completion date—the date you are completing the discharge information. The date entered here will be the identifier to roll back any open authorizations you have for this member within the Behavioral Health CareConnection® system.**

Type of Discharge: (DC_Type)

- **Planned**
- **Unplanned**

Type of Unplanned Discharge: (DC_Unplanned_Type)

- **Administrative Discharge**
- **Against Medical Advice**
- **Services not initiated by Member**
- **Lack of Participation/Missed Appointments**
- **Did Not Follow Treatment Recommendations**
- **Deceased**
- **Member Relocated (Geographic Relocation)**
- **Member Requested Discharge**
- **Aged Out of Services**
- **Corrections/Jail**

Last Day Services Provided: (DC_Last_Date_Service) Indicate the last date of service provided to the member.

Recommended Plan: (DC_Recommended_Plan) Identify the recommendation provided to the member.

- **No further treatment services needed**
- **Referred to less intensive services**
- **Referred to more intensive services**
- **Referred to same level of care services with a different provider**
- **No plan developed due to unplanned departure**

Service Outcome: (**DC_Outcome)** Identify the outcome of the services provided by your organization.

- **Symptoms ameliorated; Treatment goals achieved**
- **Symptom reduction resulting in a return to baseline functioning**
- **Progress achieved resulting in need for less intensive services**
- **Minimal progress due to increasing symptoms; Need for higher level of care**
- **Not measureable due to lack of treatment involvement**

Discussion Area: (DC_Discussion) Include any additional factors related to discharge in this free text field.