

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN		<i>Policy and Procedure</i>	
Department: Assessment Policy Author: J. Terwilliger		<i>Assessment</i>	
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I. PURPOSE

Define and standardize the minimum information necessary to determine a consumer's eligibility for services and the appropriate care, treatment, and services which meet a consumer's needs at the time of entry into services and throughout an episode of care.

II. POLICY

It is the policy of the Community Mental Health Partnership of Southeastern Michigan that all consumers will receive comprehensive assessments that ensure a consumer's need for care, the type of care needed, and the need for further assessments or evaluations are determined during an initial assessment, at least annually, at anytime there is a significant change in the consumer's status, and as requested by the consumer. Using data collected during the assessment process, standardized screening and triage criteria will be used for the referral for specialized assessments, such as substance use, health, dental, and nutritional evaluations. Assessment information guides the Plan of Service/PCP Plan.

III. APPLICATION

This policy applies to the Comprehensive Specialty Services Networks (CSSNs), the Comprehensive Specialty Services Network look-alike, contracted Substance Abuse Service Providers, and the Prepaid Inpatient Health Plan (PIHP) within the Community Mental Health Partnership of Southeast Michigan (CMHPSM)

IV. DEFINITIONS

Significant Change - A Significant Change occurs when a consumer experiences a change in functioning or circumstances. The assessment will focus on the consumer's current need and may result in change to the person centered plan that may add new outcomes, amend existing authorizations for services or supports, or add authorizations for new supports or services. A Significant Change may be the result of a positive change so that the consumer needs less service or less restrictive care, such as mainstreaming to primary care as a medical home. Or, the consumer may be at risk of, or experiencing, a decrease in functional ability or a loss of supports necessary to maintain functioning. A significant change in functioning may result from an acute illness or injury or as a result of a chronic condition. Additionally, environmental change may

lead to the need for substantial modifications in service delivery.

V. STANDARDS

- A. An assessment of an individual's biopsychosocial functioning will be conducted by a trained clinician. Any needs for additional assessments identified during the assessment will be addressed in the person centered planning process.
- B. Assessments shall be completed according to established timeframes.
 - 1. Emergency assessments occur when an individual is determined to be at eminent risk of harm to themselves or others or is unable to keep themselves safe. Emergency assessments shall be completed within three (3) hours of the request.
 - 2. Routine assessments occur when there is no apparent risk of harm to self or others. Routine assessments shall be completed within 14 days of the initial contact.
 - 3. Following initial assessments, ongoing services shall begin within 14 days of the assessment. If a consumer indicates they are unable or unwilling to meet with the assigned provider within the required timeframes, the reason for the delay will be clearly documented in the medical record.
- C. Approved screening tools and criteria will be used to determine if further assessments are required at a minimum in the areas of physical health, dental care, nutrition, functioning levels, and substance use.
- D. The assessing clinician will perform the following:
 - 1. Analyze the data and information collected during the assessment,
 - 2. Determine whether medical necessity criteria are met,
 - 3. Prioritize the individual's service needs that will assist the individual in attaining or maintaining a sufficient level of functioning in order to achieve goals of community inclusion and participation, independence, recovery, or productivity.
 - 4. At an initial assessment, develop and authorize an Interim Plan of Care which may include recommendations for additional assessments,
 - 5. At an initial assessment, assign the individual to a treatment program or refer the individual to another provider/agency that can meet his/her specific needs.
 - 6. For an annual assessment, make recommendations for ongoing supports and services as well as external referrals.
- E. Individuals with the greatest need will receive the highest priority.
- F. All assessments of consumers will be conducted by appropriately credentialed staff at each local CSSN or CSSN look a like.
- G. Assessments of adults shall include as appropriate:
 - 1. Histories of emotional, behavioral, and substance use problems and treatments including hospitalizations and medications,
 - 2. Statement of the presenting problem in the individual's own words

3. Statements of the desired outcome in the individual's own words and any preferences for care, treatment, and services.
4. Input from guardians (where applicable) family members and/or others who know the individual regarding the presenting problem and their expectations for and involvement in the treatment process
5. Information about the individual's
 - a. environment and current living situation
 - b. educational status
 - c. employment status and vocational needs
 - d. legal history
 - e. childhood history
 - f. history of abuse
 - g. history of substance use/abuse
 - i. history of addictive behaviors such as use of alcohol, drugs, gambling or other addictive behaviors by the individual and/or other family members
 - ii. age of onset for use/addiction to substances, duration and patterns of use
 - iii. consequences of the addiction (divorce, legal troubles, financial issues, job loss)
 - iv. family history of use
 - v. history of previous treatment and relapse
 - h. current emotional and behavioral functioning
 - i. maladaptive or problem behaviors
 - j. financial status
 - k. usual social, peer-group, and environmental setting, and community resources used by the individual
 - l. family circumstances and the need/desire for the family's participation
6. Assessment of imminent risk of harm to self, others, and/or property; vulnerability to abuse and neglect; and ability to keep self safe and healthy
7. Assessment of needs for supportive services
8. Cultural considerations
9. An analysis of strengths that will assist the consumer in achieving his/her desired outcomes
10. An analysis of barriers that will need to be addressed so that the consumer may achieve his/her desired outcomes.
11. A Mental Status Exam
12. A Physical Health Review that shall include the following:
 - a. medical history and identification of current medical concerns
 - b. length of time since last physical exam
 - c. assessment of pain
 - d. list of current medications
 - e. assessment of understanding of disease prevention and health promotion
13. Diagnoses on Axes I-V using the DSM-IV Manual
14. Diagnostic Summary
15. Disposition including recommendations for additional assessments, treatment goals,

program assignment, **OR** referrals to community resources if the consumer is not eligible for services from the CSSN or CSSN Look Alike.

H. Assessments of children and adolescents shall include the following in addition to that which is listed in IV. B. above:

1. Input from family members or guardians and/or others who know the individual regarding the presenting problem and their expectations for and involvement in the treatment process
2. Reports on the family history and current living situation
3. Evaluation of the family dynamics and their impact on the individual's current needs as well as their impact on discharge planning
4. Use of a developmental perspective in evaluating the individual's physical, emotional, cognitive, educational, and social functioning
5. Evaluation of the individual's play and daily activities needs
6. Evaluation of health status and immunization record

I. Assessments of persons with developmental disabilities shall include the following in addition to that which is listed in IV. B. above:

1. Input from family members or guardians and/or others who know the individual regarding the presenting problem and their expectations for and involvement in the treatment process.
2. Psychosocial assessment addressing:
 - a. comprehensive social history
 - b. adaptive behavior
 - c. social functioning
 - d. independent living skills
 - e. skills, talents, aptitudes
 - f. interests
 - g. leisure activities
3. Educational and vocational functioning assessment addressing:
 - a. education and training history
 - b. work history
 - c. work interests
 - d. work skills
 - e. work-related behavior
4. Cognitive functioning assessments conducted by a qualified licensed professional within their scope of practice addressing:
 - a. intelligence testing when needed to establish eligibility for services and results from previous testing are not available
 - b. conceptual skills
 - c. current level of concrete and abstract reasoning
 - d. screening tools will be used to determine if further assessments are required in

- the areas of :
- i. physical development
 - ii. health
 - iii. nutrition

- J. Approved screening and triage criteria for specialized assessments shall be included in the CMHPSM Utilization Review Manual.
- K. Assessments will include the identification of other health care or service providers with whom coordination of care will be needed. When possible and appropriate, information from the individual's primary care physician or other health care professionals will be used in the assessment process to determine services and supports that are medically necessary.
- L. Written assessments and completed screening tools will be included in the consumer's clinical record.
- M. Informed consent will be obtained in writing for the release of information from relevant previous and current physical and behavioral health care providers, schools, agencies, and others.
- N. Documentation shall be completed in accordance with CMHPS M and MDCH standards.

VI. REFERENCES

Reference:	Check if applies:	Standard Numbers:
CMHPSM Clinical Record Policy	X	
CMHPSM Utilization Review Manual	X	
CMHPSM Timeliness Standards	X	
Balanced Budget Act (438.208 (c) 2	X	
JCAHO 2006-2007 BHC Standards (PC 2.10-2.15, 3.10-3.30, 3.4-3.10)	X	
MDCH Standards	X	
Medicaid Provider Manual, Mental	X	Health/Substance Abuse Chapter specifically Section 2.5 Medical Necessity Criteria

VI. PROCEDURES

None