Title: Assessments Policy

Prepared By: Clinical Director

Purpose:

To define the guidelines and process for clinical assessments.

Scope:

This policy applies to all employees (including full-time and part-time employees), contract clinical providers, volunteers, students, and/or interns of Huron Behavioral Health (HBH) and all consumers served.

Information:

Clinical staff conducting clinical assessments must be qualified by education, licensure, experience, and skill. Typically, master's level clinicians with a degree in a human services field (e.g., MSW, MA, etc.) and who are also licensed in the state of Michigan (e.g., LMSW, LLPC, etc.) can conduct assessments. All clinical assessments are reviewed by the Clinical Director.

Policy:

A. Initial Assessments:

1. The HBH Intake/Admissions staff receives the initial request from the contracted access center for a new consumer and completes the required paperwork (see "Customer Service - Potential Consumer Procedure" ISP.2.05). Once scheduled, the Intake/Admissions staff will complete a "Sliding Fee Scale (SFS) Discount Program Application Form" (90-759) and other required paperwork (see also "Sliding Fee Scale (SFS) Discount Program/Ability to Pay (ATP) Policy" FM.1.11).

2. The Intake Assessment Specialist will then complete an initial independent comprehensive clinical assessment. This shall be done in a culturally sensitive manner in accordance with the Michigan Department of Health and Human Services (MDHHS) standards within fourteen (14) calendar days of referral using the "Clinical Assessment Form" in the Electronic Medical Record (EMR). HBH strives to achieve a "same day access" philosophy/approach whenever possible by offering to have the individual see the Intake Assessment Specialist the same day they seek services or within the next few days. The clinical assessment gathers information to determine level of care and appropriate services and assesses for mental health disorders, substance use disorders, and co-occurring disorders.

   Note: For individuals experiencing a crisis/emergent situation, a pre-admission screening/assessment (in EMR) is completed within three (3) hours (see "Emergency Interventions Procedure" ER.1.01).

3. The intake assessment shall be individualized, integrated, strengths-based, trauma-informed, family-focused, and culturally sensitive to the consumer/family and ensure equitable treatment and the timely initiation of services. Each person's cultural and ethnic background shall be recognized and valued including children that fall within the population covered by the Indian Child Welfare Act and/or any tribal-state agreements (see also "Services to American Indian Child Procedure" SD.2.04).

4. Upon completion of the assessment, the individual will be informed about:
   - Eligibility to receive service(s)
   - Available services
   - Information relative to the nature of their illness or diagnosis, as appropriate
   - Delays in services and the reasons for the delay (see also "Waiting List Policy" (SD.1.17)
   - Other services, programs, or organizations more appropriate to address their needs (see also "Access to Services, Eligibility, Medical Necessity, and Referrals Policy" ISP.1.01)

5. The findings from assessments including any unmet medical needs serve as the basis for treatment planning and provide for future internal and external referral. The findings of the assessment must build upon the identified strengths of the consumer.

6. Assessments follow the guidelines below:
   - The individual (or parent/legal guardian) must be the primary source of information. Collateral information may be gathered as appropriate and necessary.
   - Only the information needed to determine the medical necessity of the treatment/services is sought during the assessment process
   - Only trained and qualified staff (in accordance with state and national standards) will conduct assessments or administer tests and inventories used during the assessment process
   - Assessments assist with determining level of care and what services are medically necessary for the individual

7. The Intake Assessment Specialist will also complete a LOCUS (Level of Care Utilization System) tool for seriously and persistently mental ill (SPMI) adults, or a MichiCANS (Michigan Child and Adolescent Needs and Strengths Comprehensive Tool, or a DECA (Devereux Early Childhood Assessment) for children, as appropriate. The state-required data reporting requirements for DD Proxy Measures and Health Conditions and BH-TEDS (Behavioral Health – Treatment Episode Data Set) are also collected at the time of the assessment and entered in the EMR system.

8. Once the assessment is completed and a determination has been made, a program referral is made by the Intake Assessment Specialist. The Clinical Director reviews and makes the final approval for the transfer and the referral is sent to the appropriate program supervisor. Once the referral is completed and approved, the assigned worker has twenty-four (24) hours to make contact with consumer and schedule ongoing services. (Note – all attempts to schedule must be documented in the EMR system.). *Note* – HBH will make every effort to assign a primary worker as near to the time of intake as possible. Additionally, clinical assessments are made thoughtfully and with the intent of preventing arbitrary case re-assignments.

9. The assigned/primary worker is responsible for completing all other paperwork (Coordination of Care, Information Releases, etc.). The primary worker will also coordinate a Supports Intensity Scale (SIS) to determine support needs in various life domains for consumers diagnosed with an Intellectual/Developmental Disability (I/DD (see also "Supports Intensity Scale (SIS) Procedure" CSM.2.19).

B. Reassessments:

1. For individuals receiving extended care, updated assessments must be completed at least annually or whenever there are significant changes in the consumer's status or needs. This may be related to a change in clinical circumstances, a precipitating event, or hospitalization that results in the need for a change in level of care and the creation of a new Individual Plan of Service (IPOS) to best reflect changes in the needed service array (see also "Individual Plan of Service (IPOS) Procedure" QI.2.18). Annually, the DD Proxy measures are reviewed and updated in the EMR system for all consumers with an Intellectual/Developmental Disability (I/DD) diagnosis.

2. At the third quarterly review and the time of the IPOS Pre-plan, the worker will request the Intake/Admissions staff or Clerical Support staff to schedule an annual assessment. Once scheduled, the Intake/Admissions staff will complete a "Sliding Fee Scale Discount Program Application Form" and any other required paperwork.

3. Should another program, service, or organization be identified as more appropriate to meet the individual's needs, referrals and linkages will be made.

Definitions/Acronyms:

BH-TEDS - Behavioral Health – Treatment Episode Data Set
COA – Council on Accreditation
DD – Developmental Disability
DECA – Devereux Early Childhood Assessment

EMR – Electronic Medical Record
HBH – Huron Behavioral Health
I/DD – Intellectual/Developmental Disability
IPOS – Individual Plan of Service
LOCUS – Level of Care Utilization System
MDHHS – Michigan Department of Health and Human Services
MichiCANS – Michigan Child and Adolescent Needs and Strengths
SIS – Supports Intensity Scale

Forms:

90-164 Initial Assessment & Initial Plan Form
90-759 Sliding Fee Scale Discount Program Application Form
Clinical Assessment Form (in EMR)
Pre-Admission Screening and Assessment Form (in EMR)
MichiCANS Comprehensive Tool (in EMR)

Records:

Records of assessments are maintained in the consumer's case record in the EMR system accordance with the HBH Record Storage and Retention Policy (QI.1.23).

Reference(s) and/or Legal Authority

COA standards
CSM.2.19 Supports Intensity Scale (SIS) Procedure
ER.2.02 Emergency Services Interventions Procedure
FM.1.11 Sliding Fee Scale (SFS) Discount Program/Ability to Pay (ATP) Policy
ISP.1.01 Access to Services, Eligibility, Medical Necessity, and Referrals Policy
QI.1.05 Person Centered Planning Policy
QI.1.23 HBH Record Storage and Retention Policy
QI.2.18 Individual Plan of Service (IPOS) Procedure
SD.1.17 Waiting List Policy
SD.2.04 Services to the American Indian Child Procedure

Change History:

Change Letter	Date of Change(s)	Changes
A	03/25/04	Reformatted an brought into new Controlled Documentation system with minimal content changes
B	08/01/07	Added 90-1002 (Intake Assessment Form) 2 places, added hyperlinks, added "Pre-Admission Screening & Assessment Form" (100-006) 2 places, in "Policy" section, split out #1 & #2, revised wording in several areas for clarification w/o content changes.
C	10/01/08	Reviewed and revised to comply with COA 8th Edition Standards and present practices – reworded 5th bullet in #3 and added "including children that fall within…", added "assigned clinical" in #1, added hyperlinks, removed COA specific references (G8), added last sentence in "Records" section, added "EMR" in "Acronym" section, added reference to the Indian Child Welfare Act, added "including an integrated.." to #1, added parenthetical statement to 19th bullet in #6.
D	01/29/09	Added last bullet in #5, added #2 in "Policy" section, added "and co-occurring disorders" in #1, added to 1st sentence #4 "including any unmet medical needs"
E	02/13/13	Reviewed and revised to comply with 8th edition COA standards – in #1 added "biopsychosocial", "in a culturally sensitive manner", added paragraph in "Information" section, added reference to QI.1.05, QI.2.18, & SD.1.17 (2 places), added "(medical necessity)" to 1st bullet in #5, added 2nd sentence in #9, in #6 broke out 1st bullet into 2 bullets (from "Health and safety issues" to "Health issues" & "Safety concerns"), added 3rd from last bullet in #5, added 3rd bullet #10, in 20th bullet in #6 changed "dual diagnosis" to "co-occurring", removed 4 forms from "Forms" section (20-015, 20-016, 56-001, & OBRA Level II " removed "ACT" from "Acronym" section..
F	03/08/16	Total rewrite of policy – See Controlled Documentation Manager for copies of previous versions and/or change history.
G	11/07/17	In "Policy" section added last sentence in A.5 and added last sentence in B.1, in "Acronyms" section added "BH-TEDS", "DD" & "I/DD".
H	11/30/18	In "Policy" section A.8 added last sentence about SIS, in "Acronyms" section added "SIS".
I	09/21/20	In "Policy" section A.3 added "and ethnic", in A.4 added reference to ISP.1.01, broke #5 into #5 and #6, in 1st bullet A.6 added "parent/", in B.2 changed "Person-Centered Plan (PCP)" to "Individual Plan of Service (IPOS)", in "Acronyms" section added "IPOS" and removed "PCP", in References" section added ISP.1.01, made several minor wording/grammatical changes/corrections throughout policy without changing sentence content
J	07/24/21	In B.1 added "This may be related to a change in clinical circumstances, a precipitating event, or hospitalization that results in the need for a change in level of care and the creation of a new IPOS to best reflect changes in the needed service array."

K	09/04/21	In "Policy" section A.8 removed "In the case of children, it is staffed with the Clinical Services Manager prior to making the referral." And added "NOTE – HBH makes every effort…..of preventing arbitrary case reassignments.".
L	08/03/23	In "Policy" section A.1 added reference to 90-759 and FM.1.11, in "Forms" section added 90-759, in "References" section added FM.1.11, made several minor wording/grammatical changes/corrections throughout policy without changing sentence content.
M	09/24/24	In "Policy" section A.7 removed "CAFAS" and "PECFAS" and replaced with "MichiCANS", in "Acronyms" section removed "CAFAS" & "PECFAS" and added "MichiCANS" & "SIS", in "Forms" section added "MichiCANS".