Chapter: **CLINICAL PRACTICE**
Title: **ASSESSMENT SERVICES**

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I. ABSTRACT

This policy establishes the standards and procedures of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, to ensure that level of care authorization and the individualized plan of service development are based on thorough assessments appropriate to the needs of MCCMH persons served.

II. APPLICATION

This policy shall apply to all directly-operated and contracted network providers of MCCMH.

III. POLICY

It is the policy of MCCMH that assessments appropriate to the needs of each MCCMH person served be conducted and that level of care authorization and the individualized plan of service development be consistent with the findings of conducted assessments.

IV. DEFINITIONS

A. Access Screening
A phone or face to face screening for individuals/parent/guardians requesting MCCMH services which includes but is not limited to medical information, risk assessment, psychiatric and substance use history, diagnosis, treatment readiness, and disposition. MCCMH's Access Screening determines appropriate service providers within MCCMH's network and necessary follow-up referral(s) to services.

B. Alcohol Use Disorder Identification Test (AUDIT)
A 10-item screening tool developed by the World Health Organization to assess alcohol consumption, drinking behaviors, and alcohol related problems. The tool has been validated across genders and in a wide range of racial/ethnic groups, making it

an ideal screening tool for behavioral healthcare settings as well as primary care settings.

It is best practice to use the AUDIT at initial intake and annually thereafter, a score of 8 or higher indicates dangerous alcohol use and should prompt further assessment of the appropriate level of care for the person served based on their identified alcohol use and other presenting needs.

C. American Society of Addiction Medicine (ASAM) Patient Placement Criteria

A widely used, evidence-based, comprehensive set of standards for placement, continued service, and transfer of persons served with addiction and co-occurring conditions. The ASAM provides outcome-oriented and results-based care standards for the treatment of addiction. When preliminary screening tools, such as the AUDIT and/or the UNCOPE result in a score indicating substance or alcohol use that is dangerous, hazardous, or above the threshold for educating on the potential for addiction due to repeated, excessive, or uncontrolled use is present, the ASAM should be administered by clinicians trained in the use of the criteria to assess the appropriate level of care recommendations. ASAM criteria re-assessment is based on the person served and their current level of care, if applicable. ASAM criteria provides re-assessment frequency information. For example, levels 2.1, 2.5, 3.1 and 3.5 recommend monthly reassessments.

D. Assessments

Generally accepted professional evaluations that include health assessments, psychiatric evaluations, psychological testing, and other assessments and testing conducted by appropriately qualified and licensed health care professionals within their scope of practice for the purposes of determining eligibility for services and supports and the treatment needs of the person served. An initial assessment is provided upon entry into the system and a re-assessment is provided annually thereafter, unless clinically indicated to complete more frequently.

E. Beck Depression Inventory (BDI)

A 21-item self-report rating scale that evaluates key symptoms of depression in adults, including mood, pessimism, guilt, self-dissatisfaction, suicidal ideas, crying, irritability, social withdrawal, fatigue, loss of appetite and other core symptoms to measure the severity of depression. The BDI is used in a variety of clinical settings to support diagnostic formulation and determine the level of treatment need. The BDI can be used to further support treatment needs and may be used in conjunction with other depression screening and assessment tools, such as the PHQ-9.

F. Child and Adolescent Functional Assessment Scale (CAFAS) / Preschool & Early Childhood Functional Assessment Scale (PECFAS)

Tools used for the assessment of children enrolled in the Serious Emotional Disturbance (SED) waiver or the 1915(i) waiver, performed by staff trained in the implementation of CAFAS and PECFAS. The PECFAS is used to assess children between 3 to 7 years of age and the CAFAS is used to assess children between 7 and 17 years of age. The CAFAS/PECFAS is required at initial intake, annual reassessment, and discharge that is not part of an annual reassessment. Children

enrolled in SEDW and 1915(i) will also be assessed by the Michigan Child and Adolescent Needs and Strengths Tool (MichiCANS).

G. Children's Depression Rating Scale- Revised (CDRS-R)
A clinician-rated 17-item scale, which uses a semi-structured interview with children and/or their caregivers to assess the severity of depression in children and adolescents between 6 and 12 years of age. Individual items are summed to create a total score, which can be interpreted based on the sum. The CDRS-R can be administered in about 20 minutes and is widely used in clinical settings. This tool is recommended to be used for youth between 6 and 11 years of age to assess for the presence of depression.

H. Columbia Suicide Severity Rating Scale (C-SSRS)
A short questionnaire used to screen for risk of suicide. The scale is evidence-supported, available in 103 different languages, and is intended to help establish a person's immediate risk of suicide. It can be administered quickly in the field by clinical and non-clinical staff. The scale is relevant in a wide range of settings such as schools, primary care settings, justice systems, clinical settings, and can be used for individuals of all ages. The C-SSRS is required at initial intake, preplanning/preliminary plan of service, individual plan of service, and ongoing at every service contact (e.g., case management, psychiatric, therapy, etc.).

I. Customer Service Triage Call
The initial point of contact with MCCMH Customer Service Representative by individuals/parent/guardians calling to request MCCMH services. This includes but is not limited to the collection of demographic information, insurance verification, and basic triage of the requested services and supports. Once the information is collected, the Customer Service Representative transfers the caller to the Managed Care Operations (MCO) Division for eligibility screening.

J. Devereux Early Childhood Assessment (DECA)
A series of assessments for assessing protective factors, potential social and emotional developmental risks, and evaluating behaviors related to social and emotional resilience and social and emotional concerns in preschool children 24 months to 6 years of age.

The DECA is required at intake and during treatment planning, based on the results of the MichiCANS screener, for infants, toddlers, and children 1 month of age to 5 years of age who have a serious emotional disturbance (SED) or SED and intellectual/developmental disabilities. The DECA for infants is used for children 1 to 18 months of age. The DECA for Toddlers (DECA-T) is used for children 18 months to 36 months of age. The DECA Clinical (DECA-C) is used for children 2 years to 5 years of age.

K. Life Events Checklist (LEC)
A brief, self-report screening used to assess traumatic events in the lifetime of the respondent. The LEC assesses exposure to 16 events known to potentially result in PTSD or distress and includes an item to assess for any other potentially significant stressful or distressing event that is not captured in the previous 16 items. The Life Events Checklist is to be completed at initial intake and annually thereafter, or as

clinically indicated in the event of a significant life event and/or in the event of a proposed plan of service or behavior treatment plan which includes a request for emergency physical management as outlined in MCCMH Policy 8-008, "Behavior Treatment Plans."

L. Michigan Child and Adolescent Needs and Strengths (MichiCANS) Tool

A multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The MichiCANS is used to identify the needs and strengths of a child/youth or young adult and their families. The MichiCANS is comprised of the Screener and the Comprehensive. The Screener, used at the point of access, is a standardized format for recording key areas of functioning and intensity of specific needs. The Comprehensive is used at initial assessment, treatment planning, treatment plan reviews, and at a child and family's functioning and circumstances change. The Comprehensive is used by clinical and care coordination providers, therapist, case managers, wraparound facilitators, and others. All children and youth aged 0 through 20 years of age receiving services will require a MichiCANS Screener at point of access and Comprehensive at intake, initial individual plan of service, and annually at treatment planning. Young adults 18-20 years of age can be transitioned to adult services, where clinically indicated. The MichiCANS is not used to assess individuals in adult services.

M. Patient Health Questionnaire (PHQ-9)/ Patient Health Questionnaire modified for Adolescents (PHQ-A)

The PHQ-9 is a diagnostic tool used to screen adults in primary and behavioral healthcare settings for the presence and severity of depression. It is a 9-item self-report screener that asks about frequency of symptoms over the past two weeks. A score of 5 or higher on the PHQ-9 indicates the presence of major depression. The PHQ-A is a modified version of the PHQ-9 specifically for children and adolescents 11 to 17 years of age and like the PHQ-9 contains 9-items that screen for the frequency of depressive symptoms and the presence of a depressive disorder as described in the DSM-V. The PHQ-9 and the PHQ-A are required at initial intake, at least quarterly thereafter, or sooner as clinically indicated based on the person's needs.

N. UNCOPE

The UNCOPE is a brief, six-question screener used for identifying risk for abuse or dependence on alcohol or other substances when neither is clearly identified as a problem. The UNCOPE assesses the unintended use of substances in the past 12 months, neglect of usual responsibilities as result of substance use, the person's desire to cut down on their use, the objections of others in the person's life related to their substance use, the person's possible preoccupation with wanting to use substances and the use of substances to relieve emotional distress or boredom. The UNCOPE is a first line screening, to determine if additional and further assessment is indicated. When the score is 2 or higher, additional screening (including the AUDIT) is completed. The UNCOPE is completed at initial intake and annually thereafter, unless there is an identified Alcohol Use Disorder or Substance Use Disorder at which point more appropriate assessments shall be completed as detailed in this policy.

V. STANDARDS

A. General

1. A Triage and Access Screening shall be done by phone or face to face with individuals/parents/guardians contacting MCCMH for services.

2. Following the collection of information from the Access Screening, a referral for services is made to an appropriate provider within the MCCMH provider network or to an out-of-network provider when necessary. (See MCO Policy 2-013, "Eligibility, Admission, and Discharge.")

3. Prior to entry into service, each person shall receive a comprehensive biopsychosocial assessment (also referred to as an initial intake) to inform the planning process, propose service possibilities, and determine medical necessity. This initial assessment must be completed within fourteen (14) calendar days of a non-emergent request for services or within seven (7) calendar days of discharge from a psychiatric inpatient unit.

4. Medically necessary on-going services, including any specialized assessments, must begin within fourteen (14) calendar days of completing a non-emergent biopsychosocial assessment.

5. Additional discipline-specific assessments provided by appropriately privileged clinicians may be conducted to clarify diagnosis, levels of functioning, and need for services. Additional assessments shall be completed within thirty (30) days of the referral unless there is a clearly documented reason for the delay.

6. A physician's prescription or referral order is required for the provision of an Occupational Therapy Assessment, Psychological Testing, Physical Therapy Assessment, Speech and Language Assessment, Neurological Evaluation, and laboratory tests. See MCCMH MCO Policy 2-020, "Specialized Health Care Services," for standards regarding referral of MCCMH persons served to specialized health care services when those service needs are identified during the provision of services.

7. An Annual Assessment (also referred to as a Re-Assessment) shall be completed prior to the expiration of the Person-Centered Plan and at least annually. An updated assessment shall also be completed at any point at which the person served experiences psychiatric hospitalization or as clinically indicated because of their response to treatment.

8. Each type of assessment described herein is accessible to MCCMH persons served according to need.

9. Assessments typically provided within a particular MCCMH service program shall be repeated at intervals as specified in this policy and at any other time, as clinically necessary.

B. Initial Assessment

1. An initial assessment for a person served shall include gathering and reviewing relevant information for obtaining a brief pertinent life history including family origin, composition and relationships among family and community members, as well as information pertaining to the developmental history and significant familial health and behavioral health conditions of the person served.

2. The initial assessment should review the person's current environment, significant relationships, educational and vocational experiences, relevant medical and social histories as well as a comprehensive view of the person's lifestyle, cultural and ethnic identity, leisure pursuits and as applicable, military service, involvement with law enforcement, or substance use.

3. The initial assessment shall include gathering information within the categories outlined below:

    a. General Information (identifying information, demographics, contacts and emergency contacts, etc.)

    b. Medical History (including current medical services providers and specialty providers, where applicable)

    c. Financial Information (Salary and wages, state benefit information, etc.)

    d. Guardianship / Parent Information / Family Information

    e. Education

    f. Employment Status

    g. Legal Information (corrections related status, arrest history, etc.)

    h. Presenting Problem and Clinical History

    i. Bio-Psycho-Social Development and History

    j. Risk Assessment, including suicide (Columbia Suicide Severity Rating Scale) and homicide screening, insight and judgement, and perception assessments.

    k. Support Needs Worksheet (self-care, receptive and expressive language, mobility, self-direction, capacity for independent living, economic self-sufficiency)

    l. Cultural, ethnic, spiritual, religious considerations

    m. Person's strengths

n. Barriers to service

o. Mental status exam

p. Psychiatric history

q. Family history of mental illness and substance use

r. Brief trauma history and screening (Life Events Checklist, review of potential traumatic experiences throughout the lifetime)

s. Depression screening/assessment (PHQ9, PHQ-A, Beck Depression Inventory, Children's Depression Rating Scale or CDRS, etc.)

t. Substance use history

u. UNCOPE substance use screening

v. AUDIT/AUDIT-C

w. American Society of Addiction Medicine (ASAM) Patient Placement Criteria

x. Substance use chart

y. Moods and emotions

z. Diagnosis and treatment readiness

aa. Service Eligibility Criteria (Adults with Serious Mental Illness, Children / Adolescents with Serious Emotional Disturbance, Persons with Intellectual and/or Developmental Disabilities, Infant Mental Health)

bb. DD Proxy Measures, where applicable, include ability to make self-understood; support needs with mobility, personal care, or other functional needs; support system availability; challenging behavior needs; and use of medication for behavioral control

cc. Challenging behaviors

dd. Diagnostic formulation including specific criteria observed and/or reported to support the clinical formulation.

ee. Summary of findings and recommendations, which includes the clinical formulation and summary of the assessment from the clinician

ff. Disposition designation, indicating what recommendations are based on the summary of findings and include information on level of care, provider amount/scope/durations of services

gg. Preliminary Plan of Service

C. Additional assessments are performed as needed. These may include:

1. Psychological Testing

2. Assessment mandated under the Omnibus Budget Reconciliation Act of 1987

3. Emergency Psychiatric Pre-Admission Screening / Continued Stay Review

4. Specialty Assessments, which may include but are not limited to:

a. Occupational Therapy Assessment

b. Physical Therapy Assessment

c. Speech / Language / Hearing Assessment

e. Neurological Evaluation

5. Functional Behavioral Assessment

6. Psychosocial Rehabilitation Assessment

7. Health Assessment, which may include but is not limited to:

a. Nutritional Assessment

b. Specialized Nursing Assessment

c. Personal Health Review

E. <u>Re-Assessment</u>

1. A re-assessment shall be completed annually, or as clinically indicated, prior to the expiration of the current Individual Plan of Service (IPOS).

2. Re-assessment shall be completed in preparation for review of, updates to, and/or development of a new IPOS as clinically appropriate and in accordance with the choices and preferences of the person served. This may include, as needed, a preliminary plan of service to provide necessary services and supports for up to sixty (60) days while the full plan is developed.

3. The re-assessment shall:

a. Review the initial assessment, updating and documenting where appropriate all current information within the categories as outlined in this policy

b. Document the need for continued services

c. Document status changes from previous intake/annual assessments

F. Updated Assessment

An updated assessment shall be completed at any point in which a person served is released from a psychiatric inpatient unit, specialized nursing facility, or other more intensive care facility due to a need for a higher level of care. At such a time the following shall occur:

1. Review and update the initial assessment, as needed.

2. Document the medically necessary level of care and service array.

3. Document status at discharge and current barriers, as applicable.

4. Amend the Individual Plan of Service (IPOS) through a person-centered process.

VI. PROCEDURES

None.

VII. REFERENCES / LEGAL AUTHORITY

A. MCL 330.1712

B. Michigan Department of Health and Human Services (MDHHS) Administrative Rules, R 330.7199, "Plan of Service"

C. Commission on Accreditation of Rehabilitation Facilities (CARF) 2022 Standards Manual, §2. B., "Screening and Access to Service," pp. 138-146

D. MCCMH MCO Policy 2-001, "Person-Centered Planning Practice Guidelines"

E. MCCMH MCO Policy 2-010, "Clinical Service Documentation"

E. MDHHS Medicaid Provider Manual

F. MDHHS/MCCMH Medicaid Managed Specialty Supports and Services Contract, in effect and as amended.

VIII. EXHIBITS

None.