



Community Health &
Research Center

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I. POLICY

It is the policy of the ACCESS Community Health and Research Center (CHRC) to ensure that each individual shall receive an assessment as a part of the engagement during person-centered treatment planning. The assessment is more than information gathering. It is the beginning of the relationship between ACCESS, the clinician, and the individual. It is the beginning of building a trusting, helping relationship in which the individual may seek assistance with resolving their issues.

II. PURPOSE

To provide directions for ACCESS CHRC, its contractors and the subcontractors to ensure that the individuals served receive the necessary assessments which lead to appropriate Person-Centered Planning and referrals to other services or community resources.

III. APPLICATIONS

This policy applies to all ACCESS employees, interns and volunteers who provide support and treatment on behalf of the ACCESS CHRC.

IV. PROCEDURES

1. Each Individual will receive a psychosocial assessment as the first service after the intake is completed and annually thereafter. Assessments are conducted by qualified personnel who
 - a. Are knowledgeable to assess the specific needs of the persons served and are trained in the use of applicable tools, tests, or instruments prior to administration.
 - b. Able to communicate with the persons served.
2. Therapist interviews individual/guardian/family members and other collateral resources and obtains assessment information.
3. The assessment is key to understanding the individual and their family, strengths, abilities and past successes to address their desires, dreams, problems and needs. While

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completing the assessment documentation and related forms is required, setting this process in a conversational tone rather than an investigational style is critical. The enrolled individual shall receive a complete psychosocial assessment at intake and yearly thereafter, as well as, any other appropriate assessments as determined by the therapist.

4. Additional assessments may include (but are not exclusive of)
 - a. a psychiatric evaluation
 - b. clinical assessment
 - c. psychological testing to determine disability
 - d. LOCUS/CAFAS
 - e. PHQ-9
 - f. ASAM

The individual shall be periodically reassessed at least annually or more frequently as indicated by the person's needs or as requested by the individual/guardian. Reports of all assessments and evaluations shall be incorporated into the treatment planning process and maintained as part of the permanent clinical record.

5. If individual presents to be in an emergency situation, the emergent situation is addressed first, and the assessment will be completed at a later time. If individual presents with homicidal or suicidal ideations, intentions or plans and is in imminent risk to hurt him/her self or others, the staff notifies the ACCESS Manager or Director and calls "911" immediately. Once the individual is transported to the hospital for a psychiatric screening, an incident report is completed by all parties involved and a copy is faxed to the associated, MCCMH or DWIHN and the Quality Assurance Manager.
6. All sections of the assessment should be filled in completely during the time of the assessment. These include (but are not exclusive of) Presenting Problem/Problem Identification, Precipitating Event(s), Referral Source, Past Treatment History, Development History, Family of Origin History, Living Arrangements, Health Status, Legal Status, Educational/Employment Status, Support System, Immigration Status, Spiritual/Religious

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Affiliations, Symptoms, History of Alcohol & Chemical Use/Abuse, Trauma History, Mental Status Exam, Diagnostic Impression, Initial Treatment Plan, Discharge Criteria and Interpretative Summary.

7. Using screening criteria to identify whether individual is at high risk, the clinician screens for:
 - a. possible suicidal and/or homicidal ideation,
 - b. possible at risk of domestic violence,
 - c. possible at-risk abuse or neglect as the victim or perpetrator,
 - d. identification of use of alcohol, tobacco or other drugs. If the individual has alcohol or chemical use problem or a DAST or MAST is completed.
8. The above is documented in the individual record and referrals are made to the physician, substance abuse treatment, VOCA, ORR or Mental Health and Family Counseling.
9. Each individual with a finding consistent with a disorder of mood, thought, or behavior that may benefit from medication shall receive a psychiatric evaluation performed by a psychiatrist who meets the requirements stated in the Mental Health Code [MCL 330.1100c (10)]. If a medication may be indicated, a referral to a psychiatrist is completed. The psychiatrist completes a psychiatric evaluation and may have a role the individual's treatment plan goal or objectives related to medication management.
10. Each individual with a finding of a developmental disability shall receive a battery of psychological testing and specialty evaluations (Medical, Physical Therapy, Occupational Therapy, Speech and Language) as appropriate to his/her condition. These specialty services may be delivered by coordination by the ACCESS Case Manager by referral to external service providers.
11. In addition, the therapist may collect pertinent collateral information and health records to enhance information obtained by Individual's verbal report. Each individual with a finding of physical disability shall be referred for specialty evaluations as appropriate to his/her condition. Each individual with a finding of a current nutritional deficit or a potential for nutritional risk shall receive an evaluation performed by a registered dietitian. If these services are not available by other ACCESS programs, the ACCESS Case Manager shall make the appropriate referrals.
12. The clinical record shall be reviewed periodically to assure completion of all referred and

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deferred examinations and procedures. If any element of an initial evaluation is deferred, the reason for the delay and the expected date of completion shall be documented in the individual's clinical record. The clinical record shall be reviewed periodically to assure completion of all deferred examinations and procedures.

13. Based on assessment findings and admission criteria, individuals will be placed in the appropriate level of care and programs/groups within ACCESS Mental Health and Family Counseling. ACCESS Mental Health and Family Counseling provides an array of services for children and their families that include:

- a. Emergency services, including emergency evaluations
- b. Evaluation and screening
- c. Referrals
- d. Case management
- e. Outpatient Individual and family therapy
- f. Outpatient substance abuse treatment
- g. Prevention services
- h. Peer Specialist

14. Individuals shall be offered the appropriate level of care/program along with an orientation to the programs and services available at ACCESS. If the individual concurs the Person-Centered Treatment Planning continues.

15. ACCESS employs clinicians who are qualified by training and have supervised experience to diagnose and treat children with serious emotional disturbance and/or developmental disabilities, and who meet the requirements for Child Mental Health Professional Credentials, Criminal Background Check and Central Registry.

16. If a former individual of a clinician's returns to treatment after discharge period of less than six (6) months, case may be reassigned to the same therapist if available. If individual returns after 6 months he/she will have to go through the screening process to assess the current status and level of care needs. Former individual must articulate their desire to be readmitted by identifying their crisis (motive) for readmission and must demonstrate their readiness to reengage in treatment by disclosing their plans for recovery.

17. Discharge planning typically starts at time of assessment and the discharge criteria are

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documented as such on the assessment and treatment plan.

18. If the individual is found ineligible for services available based on assessment findings and the admissions criteria, the therapist will make appropriate referrals to assist the individual in finding needed services. A variety of services can be found in the Directory of Community Resources. If the individual is found to be ineligible for admission, the therapist will document this decision in the medical record. The option for Second Opinion is also offered to the individual.

19. When appropriate, coordination with other entities that service the youth and their families, i.e., primary care physicians, schools, Department of Health and Human Services, and the Juvenile Justice System shall occur with documentation in the case record, which includes a signed release of information form. There should also be documentation in progress notes indicating attempts made to get information from other human service entities including primary care physicians. If linking and coordinating with outside agencies or community resources are needed, a referral for a case manager is completed. The case manager completes a case management assessment and is part of the plan to refer and monitor outside services

20. The Initial Assessment must be reviewed and signed by the psychiatrist during the initial Psychiatric Assessment. Completed assessments are maintained in the individual's medical record. Any collateral information and health records from other sources are also maintained in the medical record and not available for re-release per Federal Confidentiality Guidelines.

21. A reassessment is completed at least annually or as individuals needs change or if the individual requests a reassessment.

22. Using the individual expressed goals for treatment, a Family-Centered Treatment Plan will be developed that addresses the expressed desires and needs of the identified individual and their family after they have participated in a pre-planning process. The assigned clinicians shall ensure that the actual provision of each service is documented on an individual basis in the case record according to Person/Family Centered Planning process.

23. The clinician(s) shall ensure that families are provided information about accessing respite services during the Person/Family Centered Planning process. It should be

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documented on the pre-planning form, dated and initialed by the families that they have been offered this service. They also shall ensure that all families of children and youth that are Medicaid eligible have information regarding their right to Early Periodic Screening, Diagnostic and Treatment Services (EPSDT). There must be documentation in the case record that is signed by family/guardians that they have been informed of this service, and if requested, assist with accessing this service. If families have accessed this service, clinicians should request copies to be included in the case record.

24. Clinicians shall provide emergency telephone numbers Include toll free, TTY, and TDD telephone numbers on all publicly distributed publications that are distributed to the public.

V. QUALITY ASSURANCE/IMPROVEMENT

ACCESS Quality Assessment and Performance Improvement Program (QAPIP) must include measures for both monitoring of and for the continuous improvement in quality of the program or process described in this policy.

VI. COMPLIANCE WITH ALL APPLICABLE LAWS

ACCESS Employees, interns and volunteers are bound by all applicable local, state, and federal laws, rules, regulations, and policies, all federal waiver requirements, state, and county contractual requirements, policies, and administrative directives in effect and as amended.

VII. LEGAL AUTHORITY AND REFERENCES

Michigan Mental Health Code, P.A. 258 of 1974, as amended; MCL 330.1710; MCL 330.1752
 Agency Policies (All Agency Policies refer to the most recent at the time of writing) ACCESS
 Policy and Procedures Access to Services and exhibits
 Consent to Treatment and Services
 Individual Plan of Service/Person-Centered Planning
 Treatment with Dignity and Respect
 Use of Psychotropic Medication and Medical Services

VIII. EXHIBITS

Sample of Assessment Form Heading