

HEALTHWEST

Procedure

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Subject: Professional Assessment

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I. PURPOSE

- A. To identify someone's individual need for behavioral health and substance use disorder treatment services.
- B. To identify and define different types of assessments.
- C. To establish guidelines and procedures for professional assessments.
- D. To reduce duplication of staff effort in assessing individuals receiving services.

II. APPLICATION

All HealthWest employees and contract providers conducting and/or identifying needs for assessment services.

III. DEFINITIONS

For the purposes of this procedure, terms are defined as follows:

- A. Screening: A process of compiling initial data to determine if an individual meets eligibility criteria based on established clinical and financial information.
- B. Assessment: Process of evaluating the physical, cognitive, behavioral, and emotional needs of an individual that, after clinical consideration of those needs, may result in ongoing HealthWest services or a referral to an appropriate community resource

IV. PROCEDURE

The person's needs will determine the type and level of assessment provided.

A. REQUEST FOR SERVICE/INTAKE

- 1. Description: A brief phone or face-to-face screening completed at the time of an individual's request for services. This screening will determine the need and level of care required, as well as the need for further assessment.

2. **Open Access:** An open access model of services utilized by HealthWest; generally results in a full Initial Assessment at the time of a face to face request for services. This will include a pre-plan for an initial thirty (30) days of service and connection to a provider team internally or result in a referral and connectivity to another agreed upon provider.
3. **Responsible worker:** The request is processed by phone through an Access Center staff person, or face to face by an emergency services staff person. A master's level person conducts the Service Entry Assessment.
4. **Content:** Demographics, eligibility, and emergency status are identified, as well as presenting problem, history of mental health difficulties and treatment, relevant current medical status, substance abuse, plus any information needed to determine level of care need and facilitate a referral to the appropriate service. Any positive responses in the medical risk screening, substance abuse will result in an evaluation for the need of further assessment in these areas.
5. **Documentation:** Service requests are documented by Access or Emergency Services Staff screening form or a Service Entry Assessment document.

B. EMERGENCY/CRISIS ASSESSMENT

1. **Description:** Evaluation for the prompt detection of substance use disorder or acute symptoms including need for detox or any mental health problem that may be life threatening to self or others, and may be indicative of possible decompensation which, if left untreated, may render the individual unable to provide for self-care/safety. The intervention is conducted at the time of request or when a need is indicated, and is repeated until the crisis is resolved. Emergency appointments are available by appointment or walk-in basis during normal working hours. Situations which are acute and require preadmission screening or risk assessment are conducted in the emergency room.
2. **Responsible Worker:** Assessment of emergency situations occurs face to face, or through phone contact, by the primary worker or by Emergency Services/Access staff.
3. **Content:** When a risk of harm to self/others is suspected, the assessment will include the following: severity of illness/disability, level of risk, psychiatric symptoms, disruption of self-care abilities, any medication/drug or medical complications and intensity of services and disposition.
4. **Documentation:** Emergency staff will document non-gatekeeping.

C. CLINICAL ASSESSMENT

1. **Description:** A initial Clinical Psychosocial Evaluation of each individual's emotional, behavioral, social, and physical status including substance use disorder/chemical dependency, to determine the need for care, the level and type of care to be provided, and the need for further assessment and services. In cases where the individual is referred to multiple services, there will only be one Clinical Assessment, which will serve as the basis for providing those services.
2. **Responsible Worker:** A Clinical Assessment is conducted by a master's level clinician.

3. Content: The majority of individuals will receive an initial assessment. In the ECR this is the Service Entry Assessment including:
 - a. Presenting Problem includes primary reason for requesting services as well as the individual's current symptoms and precipitating factors.
 - b. Current emotional, behavioral, and adaptive functioning; substance abuse/chemical dependency needs.
 - c. History of emotional, behavioral, and substance abuse problems, including history of prior mental health/psychiatric services.
 - d. A focused evaluation of the quality of the individual's psychosocial functioning as relates to the primary reason for service, and considering the following:
 - 1) Family members/living situation.
 - 2) Environmental, cultural, and ethnic factors.
 - 3) Childhood development. (Include the Child Addendum if information is needed for a youth or DD individual.)
 - 4) Educational history/needs, including age and ability appropriate information regarding:
 - a) Illness or disability specific information;
 - b) Formal education.
 - 5) Socialization, peer relationships.
 - 6) Community inclusion.
 - 7) Safety issues.
 - 8) Leisure, recreation and daily activities.
 - 9) Legal involvement, including guardianship and custody issues, legal offenses, probation/parole status, etc.
 - 10) Military service history.
 - 11) Employment including if the individual is employed, job stability, do they desire employment and do they need assistance with finding employment.
 - 12) Financial status.
 - 13) Significant health issues and how this affects the individual's behavioral health issues and quality of life issues.
 - 14) Substance abuse /Chemical dependency, current and past including drugs, alcohol, tobacco. Also address family history of readiness for change, history of substance abuse treatment and activities which support recovery.
 - 15) FASD prescreen for all children who presents for assessment and made available to every parent who presents for assessment.
 - 16) Present or history of physical and sexual trauma, abuse, and neglect.
 - 17) Case management needs.
 - 18) Previous behavioral health services including diagnostic information, treatment information and efficacy of current or previously used medications.
 - 18) Strengths and resources, including individual strengths, support from family and friends and community resources utilized by individual and family.

- 19) Interpretative Summary
- 20) Referrals/disposition
- 21) Diagnosis Axis I-V
- 22) DD Addendum to be filled out on all DD individuals. This includes
Self-care
Language
Learning
Mobility
Self-direction
Independent living

e. Determination of need for further specialized assessment, including but not limited to:

- 1) Psychological Testing (specified need for intellectual, adaptive, neuropsychological, and/or personality assessment).
- 2) Psychiatric Assessment.
- 3) Chemical Dependency/Substance Abuse using ASAM.
- 4) FASD Assessment
- 5) Vocational Assessment.
- 6) Physical Therapy Assessment.
- 7) Adaptive/Environmental Assessment (Occupational).
- 8) Initial Physical Health Assessment.
- 8) Nutritional/Dietetic Assessment.
- 9) Other Functional Assessments.

f. Recommendations for treatment/service planning, based on:

- 1) Priority of need.
- 2) Appropriate least restrictive service.
- 3) Family/support person's involvement.
- 4) Person Centered Planning.
- 5) Application of the Service Selection Guidelines.

E. PSYCHIATRIC EVALUATION

1. Description: A comprehensive evaluation, performed face-to-face by a psychiatrist, clinically supervised physician's assistant, or nurse practitioner, that investigates the individual's clinical status for the purpose of determining mental and emotional functioning and capacities, the presence or absence of pathology, and recommending a course of treatment, if needed. Psychiatric Evaluation and Re-evaluation may be completed at any time in the course of treatment as determined by need.
2. Responsible Worker: Psychiatric Evaluations are completed by an appropriate licensed and privileged psychiatrist, Physician's Assistant, or Nurse Practitioner. Requests for Psychiatric Evaluation are initiated by the individual's physician, primary/designated worker, intake worker, or emergency services worker.
3. Content: Psychiatric Evaluations are to include a summary of the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; a mental status examination; summary of positive findings; a bio-psychosocial formulation and

diagnostic statement; an estimate of risk factors; initial treatment recommendations; estimate of length of stay when indicated; and, criteria for discharge.

4. Documentation: Information is to be documented in a Psychiatric Assessment Report and entered in the person's record.

F. CHEMICAL DEPENDENCY/SUBSTANCE ABUSE

1. Description: A Comprehensive Assessment of an individual's chemical dependency and/or alcohol/substance use/abuse and factors which need to be considered when determining specific substance abuse treatment needs.
2. Responsible Worker: Qualified personnel at HealthWest or another provider preferred by the consumer will conduct substance abuse assessment using ASAM in particularly when a primary SUD diagnosis is likely.
3. Content: A Substance Abuse Assessment will include information pertaining to the following:
 - a. Detailed history or alcohol and other drug use, including age of onset, duration, patterns, and consequences of use;
 - b. History of physical problems associated with dependence;
 - c. Use of alcohol and other drugs by family members;
 - d. Spiritual orientation;
 - e. Treatment recommendations and prognosis for success of treatment.
4. Documentation: Substance Abuse Assessment information will be documented on an appropriate form and entered in the individual's record. When an assessment is completed at an outside agency, appropriate authorization(s) to exchange information will be obtained, and the assessment filed in the person's record.

G. VOCATIONAL ASSESSMENT

1. Description: Assessment of a person's vocation capacities, assets, limitations, and work related behaviors.
2. Responsible Worker: Vocational Assessments are completed by a registered occupational therapist, HealthWest Vocational Staff or a certified rehabilitation counselor from a provider agency.
3. Content: A Vocational Assessment will include but not be limited to the following information:
 - a. Educational.
 - b. Mental health history, including medications and what the person does to support personal wellness.

- c. Physical health issues.
 - d. Substance usage.
 - e. Legal History
 - f. Activities of daily living.
 - g. Work interests, history, skills, tolerance, habits.
 - h. Monetary Benefits received.
 - i. Social supports/networks.
 - j. Transportation
 - k. Vocational options and objectives.
 - l. Recommendations.
4. Documentation: A Vocational Assessment will be documented and entered into the individual's record. When completed by an outside agency, the assessment will be obtained and filed in the individual's record.

H. PHYSICAL THERAPY EVALUATION

1. Description: Assessment of physical abilities for the individual to achieve optimum physical functioning, to prevent further dysfunction, and to promote health by the application of physical-oriented or goal-oriented activity, and to recommend a course of therapeutic intervention/treatment.
2. Responsible Worker: A Physical Therapy Assessment is completed by a qualified licensed and registered physical therapist.
3. Content: A Physical Therapy Assessment will include but not be limited to the following information:
 - a. Reason for assessment
 - b. Treatment-related diagnosis/pertinent medical history
 - c. General Observations
 - d. Evaluation of:
 - 1) Mobility, including muscle tone and strength, transfers and gross motor skills, balance/coordination and ambulation/gait pattern.
 - 2) Range of motion and flexibility – hip, knee and ankle.
 - 3) Strengths and abilities.
 - 4) Concerns and safe-related issues.
 - 5) Physical therapy-related equipment.
 - 6) Recommendations
 - 7) Goals and objectives.
4. Documentation: Physical Therapy Assessment results as listed above will be documented by the evaluating physical therapists and entered into the individual's record.

I. ADAPTIVE/ENVIRONMENTAL ASSESSMENT (Occupational Therapy)

1. Description: Assessment of the individual's current physical and cognitive function in relation to occupation-oriented or goal-oriented activities. A recommended course of treatment is identified to obtain optimum functioning, to prevent dysfunction, and to promote health in such activities.

2. Responsible Worker: An Adaptive/Environmental Assessment is completed by a registered occupational therapist.
3. Content: An Adaptive/Environmental Assessment will include, but not be limited to the following areas:
 - a. Reason for assessment
 - b. Treatment related Diagnosis
 - c. General Observations
 - d. Evaluation of:
 - 1) Mobility, including ambulation/transfers, range of motion, muscle tone/strength, fine/gross motor skills
 - 2) Physical Environment
 - 3) Sensory
 - 4) Activities of Daily Living, including dressing, eating, grooming/hygiene, toileting, home living skills, personal business, safety
 - e. OT Related Equipment
 - f. Vocational Status
 - g. Goals and Objectives
 - h. Recommendations for service/treatment needs, residential placement needs, and vocational needs.
4. Documentation: Assessment results will be documented by the evaluating occupational therapists and entered into the individual's record.

J. SPEECH, HEARING, AND LANGUAGE ASSESSMENT

1. Description: An assessment of an individual's functional communication abilities.
2. Responsible Worker: A Speech, Hearing, and Language Assessment is completed by a qualified, licensed speech pathologist or audiologist.
3. Content: A Speech, Hearing, and Language Assessment will include but not be limited to the following information:
 - a. Reason for referral
 - b. Clinical Impressions
 - c. Communication history
 - d. Evaluation, including as needed assessment of hearing impairment, assessment of ability to augmentative communication, speech deficit/skills, swallowing dysfunction, specific testing if necessary
 - e. Present Objectives
 - f. Progress with Objectives
 - g. Summary and Recommendations
 - h. Goal and objectives
4. Documentation: Information will be documented on an appropriate form, and entered into the individual's record.

K. NUTRITIONAL/DIETARY ASSESSMENT

1. Description: A comprehensive evaluation of nutritional status, which uses medical, nutrition, and medication intake histories; physical exam information; body size, weight, and proportion comparisons; and laboratory data.
2. Responsible Worker: Person who has obtained certification as Registered Dietician.
3. Content: Assessments will be done according to HealthWest Procedure #1-041 after referral from RN with physician order.
4. Documentation: The assessment will be documented on an appropriate form and entered into the individual's record.

L. PHYSICAL HEALTH ASSESSMENT

1. Description: A comprehensive assessment which includes a medical history and a physical examination.
2. Responsible Worker: Physical Health Assessments are performed by an appropriately state licensed physician, or physician's assistant.
3. Content: A Physical Health Assessment should include:
 - a. Complete medical history,
 - b. Known diseases,
 - c. Hospitalization history,
 - d. Medications (current and past),
 - e. Infectious/Communicable diseases,
 - f. Types of and responses to treatment.

Physical Health Assessments are performed within one week after admission to Brinks Residence unless one was performed within the last thirty (30) days and a verifiable copy is obtained.

4. Documentation: Information will be documented on an appropriate form and entered into the individual's record.