

# ASSESSMENTS



Los Angeles County DMH  
Program Support Bureau  
Quality Assurance Division  
October 2010

10/5/10

# Agenda

---

- Clinical Loop
- Overview of Assessment utilizing a Recovery Perspective
- Documenting in the Assessment
- Assessment Forms
- State Minimum Requirements in the Assessment
- Questions and Answers



# The Clinical Loop

---

The “Clinical Loop” is the sequence of documentation that supports the demonstration of ongoing medical necessity and ensures all provided services are Medical reimbursable



# The Clinical Loop

---

- That sequence of documentation on which Medical Necessity requirements converge is:
  - The Assessment
  - The Client Care Plan
  - The Progress Note



# The Clinical Loop

---

- Step One - Completion of a Mental Health Assessment including:
  - Symptoms/Behaviors leading to an Included Diagnosis
  - Impairments in Life Functioning, Needs, and Strengths
  
- Step Two - Carry this information forward into the Client Care Coordination Plan (CCCP) and document:
  - Goals/Objectives linked to the identified Symptoms/Behaviors
  - Interventions to effect the identified impairments
  
- Step Three - Carry these goals/objectives forward into the Progress Note which documents:
  - Goal-based interventions provided to client



# Overview

---

- ❑ **Assessment** is a clinical analysis of a client's history and current status of mental, emotional, or behavioral disorder; relevant cultural issues and history; diagnosis; and testing procedures (§1810.204)
  - The Triage process is a separate process from the Assessment process
- ❑ Only **Authorized Mental Health Disciplines (AMHD)** can fully complete an Assessment
  - Licensed MD/DO
  - Certified NP (Nurse Practitioner)
  - Registered CNS (Clinic Nurse Specialist)
  - Registered Nurse
  - Licensed or Registered and waived PhD or PsyD
  - LCSW or Registered MSW (Associate Clinical Social Worker – ASW) or out-of-state Licensed-Ready Waivered MSW
  - Licensed MFT or Registered MFT (MFT Intern) or Out-of-State Licensed-Ready Waivered MFT
  - And students of these disciplines with co-signature



# Purpose of the Assessment

---

- ❑ Begins to help you understand and appreciate who the person is and the role of culture and ethnicity in his/her life
- ❑ Enables the reader to see the interrelationships between behaviors/symptoms and the whole person
- ❑ Documents impact of collaterals, living situation, substance use/abuse, etc. on mental health of the client
- ❑ Identifies individual's and family's strengths
- ❑ Identifies stages of change/recovery for the client (i.e. where is the client at?)
- ❑ Collect foundation information that will help the individual and staff to create a treatment and recovery plan together
- ❑ Bridge between the information gathered from the individual and the creation of the plan



# Overview

---

- Initial assessments must be completed within 2 months of intake for clients with no other open episodes or within 1 month for clients with an open episode elsewhere in the System
  - While the Department allows this time to complete the initial Assessment, there must be some documentation of mental health symptoms/impairments that support the continuation of the assessment process if services are to be claimed to Medi-Cal
  - It is important to note that if impairments that support an included mental health diagnosis are not documented by the second or, in difficult to assess clients, the third claimed service the risk of possible audit exception increases and continues increasing until impairments are documented





# Overview

---

- ❑ Any facility accepting a client is responsible for assessing that client
- ❑ When an episode is originally opened, it may not be clear what diagnosis is appropriate due to the need to gather additional information or complete the full Assessment.
  - If impairments can be identified and “No Medical Necessity” has not been ascertained, the episode may be opened with a “799.9 Deferred Diagnosis” on Axis I
    - ❑ An Episode cannot be closed with a “Deferred Diagnosis.” It may be closed with “V71.09 No Diagnosis” on Axis I.
  - As soon as a diagnosis is determined, both the clinical record and the IS must be updated with the correct diagnosis within the Assessment period
    - ❑ A diagnosis must be determined prior to the end of the Intake Period



# Assessment Forms

---

- ❑ DMH Approved Assessment forms MUST be used without alteration-Contract and Directly-Operated
- ❑ Initial Assessment (Adult, Child/Adolescent, 0-5): Used for long term treatment
- ❑ Short Format Assessment (Child and Adult): When services are only for a brief period of time or when services are only for the purpose of linkage and referral
- ❑ EOB/UCC Assessment: Used by PMRT and UCC programs
- ❑ Assessment Addendum: used to update information in an assessment at any point during the episode or if a full assessment was completed within the past 12 months by another agency and faxed to you
  - If a comprehensive assessment has been completed by another agency in the last 12 months, a copy of that assessment can be filed in the clinical record and used as a baseline for the new agency's assessment
  - The Assessment Addendum should be used to update/confirm information on the original assessment



# Annual Assessment Update

---

- **Definition:** A brief re-assessment completed annually for all clients
- **Purposes:**
  - Verifies continued Medical Necessity (signs/symptoms/impairments) or appropriateness of services
  - Documents any significant change in the client's life
  - Describes progress the client has made toward meeting goals since the last assessment
- Due annually upon the month of intake



# Documenting

---

- ❑ If all information for the initial assessment is gathered in one assessment contact
  - Reference initial assessment completed in the Progress Note
    - ❑ Completed Initial Assessment (see Initial Assessment dated xx/xx/xx in clinical record)
  - Sign/date the assessment as of the date of the assessment contact
- ❑ If information for the initial assessment is gathered in multiple assessment contacts,
  - Reference sections of the initial assessment completed in each Progress Note
  - Sign/date the sections subsequently added to the initial assessment
  - Sign/date the assessment as of the date of the last assessment contact
- ❑ If information is gathered AFTER the initial assessment period, an Assessment Addendum MUST be used instead of adding to the Assessment



# Correcting Information in the Assessment

---

- When incorrect information is in the original Initial Assessment:
  - If you completed the Initial Assessment and are simply correcting a mistaken entry within the initial assessment period, then cross out, write mistaken entry, initial and date
  - If you were not the Rendering Provider who completed the Initial Assessment or it is past the initial assessment period or the information in the Initial Assessment needs to be updated with new information, then an Assessment Addendum must be completed



# State Minimum Requirements

---

- ❑ Presenting problems (symptoms/behaviors)
- ❑ Conditions affecting life functioning (impairments)
- ❑ Special status situations and risks to client or other
- ❑ Client strengths
- ❑ Mental health history, previous treatment dates, providers, therapeutic interventions and responses
- ❑ Relevant family information
- ❑ Physical health conditions reported by the client
- ❑ Allergies/adverse reactions
- ❑ Medication, dosages, dates of initial prescription/refills
- ❑ Substance Use
- ❑ Developmental history (for children)
- ❑ Mental status
- ❑ Five Axis Diagnosis



# Presenting Problems (Symptoms/Behaviors)

---

## □ Points to Remember:

- Gives justification for the diagnosis
- List current symptoms/behaviors
- Identifying frequency is fundamental in developing SMART goals/objectives on the CCCP
- If client is on medications and symptoms/behaviors are reported to be stable, document that medications are needed to maintain and/or stabilize former symptoms/behaviors



# Presenting Problems (Symptoms/Behaviors)

---

- Documented on AIA

- Page 1 Section II

- Documented on CAIA

- Page 1 (Reason for Referral/Chief Complaint)





# Presenting Problems (Symptoms/Behaviors) Activity

---

- How would you document the following:
  - Depression
  - Anxiety
  - Psychotic Symptoms
- What frequencies can you use?
  - Days per week
  - Times per day
  - Percentages
  - Strength
  - Amount of distraction



# Impairments

---

- Ways in which presenting problems (symptoms/behaviors) affect the client's physical and mental health status
  - Living situation
  - Daily activities
  - Social support
  - Financial
  - Legal
  - Employment
  - Education
- Points to Remember:
  - Document why there is an impairment
    - Important to Medi-Cal Claiming
    - i.e. client cannot maintain employment due to periods of depression that make it difficult to get out of bed
    - i.e. client's inability to focus causes difficulty sitting and getting his homework done
  - Can be documented throughout the Assessment



# Impairments

---

## □ Documented on AIA

- Page 1 Section II
- Page 1 Section III (Psychiatric History): for client's on medications or who have obtained stability
- Page 2 Section IV (Medical History)
- Page 2 Section V (Substance Use)
- Page 3 Section VII (Psychosocial History)

## □ Documented on CAIA

- Page 1 (Reason for Referral/Chief Complaint)
- Page 2 (Additional Problem Areas/Associated Behaviors) – Peer Problems
- Page 3 (Medical and Psychiatric History) – Prior Mental Health History: for client's on medications or who have obtained stability
- Page 5 (Other Information) – School, Vocational, Juvenile Court
- Page 6 (Current Living Situation) – Family Relationships



# Impairments Activity

---

- What would be important to document with the following impairments?
  - Homeless
  - Not working
  - Hearing Loss
  - Poor Balance
  - Expulsion from school
  - Fights with peers
  - No social network



# Special Status Situations

---

- Situations that present a risk to client or others
  - DCFS Involvement
  - Physical Impairments/Disabilities
  - Medical Conditions
  - Legal History
  - Dependents in the home
- Points to Remember:
  - Can be documented throughout the Assessment



# Special Status Situations

---

## □ Documented on AIA

- Page 2 Section IV (Medical History)
- Page 3 Section VII abcf (Psychosocial History- Family & Relationships, Dependent Care Issues, Current Living Arrangement & Social Support Systems, Legal History)

## □ Documented on CAIA

- Page 1 (Agency of Primary Responsibility)
- Page 3 (Medical History)
- Page 5 (Juvenile Court History, Child Abuse & Protective Services History)
- Page 6/7 (Current Living Situation)



# Client Strengths

---

- The personal resources that get an individual through adversity; personal resources (internal and external)
- Points to Remember:
  - Strengths can include unique individual attributes, abilities, accomplishments, resources, relationships, natural supports, hopes and dreams, sources of motivation
  - Should be documented throughout the Assessment



# Strengths Based Assessment: Qualities/Personal Characteristics

---

- Unique individual attributes
- Examples:
  - Honest
  - Caring
  - Hopeful
  - Hardworking
  - Kind
  - Patient
  - Sensitive
  - Talkative
  - Friendly
  - Resilient
  - Humorous
  - Creative





# Strengths Based Assessment: Skills/Talents

---

- Abilities, competencies and accomplishments
- Examples:
  - Good card player
  - Good at math
  - Computer wiz
  - Good at managing money
  - Skilled musician
  - Good at art/creating
  - Good writer/poet



# Strengths Based Assessment: Environmental Strengths

---

- Resources, relationships, natural supports
- Examples:
  - Has a safe place to live
  - Part of a local church or community group
  - Has his own apartment
  - Her dog Max is her best friend
  - Has access to public transportation and uses it



# Strengths Based Assessment:

## Interests / Aspirations

---

- Hopes and dreams, sources of motivation
- Examples:
  - Wants to be a rock star
  - Loves to fish
  - Likes to watch old movies
  - Want to train dogs professionally
  - Likes to hang out with friends at the local coffee shop
  - Wants to get own car
  - Wants to get BA degree
  - Spirituality



# Client Strengths

---

## □ Documented on AIA

- Page 3 Section VII (Psychosocial History)
- Page 5 Section IX (Diagnostic Summary)

## □ Documented on CAIA

- Page 1 (Reason for Referral/Chief Complaint) - Strengths
- Page 5 (Other Information) – School, Vocational
- Page 6/7 (Current/Past Living Situation) – Family Strengths
- Page 9 (Summary and Diagnosis) – Diagnostic Summary



# Strengths Based Assessment Activity

---



**Think of someone you admire...**

10/5/10

29



# Mental Health History

---

- Includes:
  - Previous treatment dates
  - Providers
  - Interventions and responses
- Points to Remember:
  - Can reference other source documents such as IS screen prints or previous treatment assessments in the Clinical Record



# Mental Health History

---

## □ Documented on AIA

- Page 1 Section III  
(Psychiatric History)

## □ Documented on CAIA

- Page 2 (Medical and Psychiatric History) – Symptoms/Behaviors
- Page 3 (Medical and Psychiatric History) – Prior Mental Health History



# Medications

---

- Includes:
  - Name of
  - Dosage
  - Dates of initial and refill prescriptions
  - Be sure to document if client is currently on medications
- Important to Remember:
  - If a client is not aware of medications, dosage, etc be sure to document this
    - i.e. unknown by client
    - And remind the client to try to gather this information prior to seeing the psychiatrist





# Medications

---

- Documented on AIA

- Page 2 Section V  
(Medications)

- Documented on CAIA

- Page 3 (Medical and  
Psychiatric History) –  
Prior Mental Health  
History



# Allergies and Adverse Reactions

---

- Allergies and Adverse Reactions MUST be completed
  - Never leave blank
  - If information is unknown, be sure to document that information is unknown



# Allergies and Adverse Reactions

---

## □ Documented on AIA

- Page 2 Section IV (Medical History)
- Page 2 Section V (Medications)

## □ Documented on CAIA

- Page 3 (Medical and Psychiatric History) – Prior Mental Health History
- Page 3 (Medical and Psychiatric History) – Medical History



# Relevant Family Information

---

## □ Points to Remember:

- If family will be involved in treatment or impacts client's mental health, clearly document why family should be involved or how family impacts client's mental health
- For children, this could include current and past living situations
- For adults, be sure to obtain authorization to speak with family members



# Relevant Family Information

---

## □ Documented on AIA

- Page 1 Section III c (Psychiatric History- Family history of mental illness)
- Page 3 Section VII a (Psychosocial History- Family & Relationships)

## □ Documented on CAIA

- Page 2 (Medical and Psychiatric History) – History of Presenting Problem *Relevant Factors*
- Page 4 (Environmental Stressors)
- Page 5 (Other Information) – Child Abuse & Protective Services History
- Page 6/7 (Current/Past Living Situation)



# Physical Health Conditions

---

- Important to Remember:
  - Be sure to document where information is coming from
    - While the IS does not allow for additional information, it is important to document in the Assessment where information is coming from
      - i.e. per client's report...



# Physical Health Conditions

---

## □ Documented on AIA

- Page 2 Section IV (Medical History)
- Page 5 Section IX (Summary and Diagnosis) - Axis III

## □ Documented on CAIA

- Page 3 (Medical and Psychiatric History) - Medical History
- Page 9 (Summary and Diagnosis) - Axis III



# Substance Use

---

## □ Points to Remember:

- For Adults, use the COJAC to determine if a substance use assessment is needed
  - If substance use services will be provided, Section VI MUST be completed stating how mental health is impacted by substance use
- For Children, if the child is 11 or older OR there is some indication that substance use is involved a substance use assessment is required





# Substance Use

---

## □ Documented on AIA

- Page 2 Section VI (Substance Use/Abuse)
- Page 5 Section IX (Summary and Diagnosis) - Axis I

## □ Documented on CAIA

- Page 3 (Medical and Psychiatric History) - Substance Use Overview
- Page 9 (Summary and Diagnosis) - Axis I



# Developmental History

---

- Only required for children



# Developmental History

---

- Documented on AIA
  - Not required
- Documented on CAIA
  - Page 4 (Medical and Psychiatric History) – Developmental History
  - Page 4 (Medical and Psychiatric History) – Developmental Milestones



# Mental Status

---

- Points to Remember:
  - Never leave sections blank
    - It implies that the question was not asked or it was asked and not documented
  - The mental status exam is for current mental status
  - On the adult form, “Medications” checkbox assists in identifying that the client was on medications at the point of the mental status exam



# Mental Status

---

- Documented on AIA
  - Page 4 Section VIII

- Documented on CAIA
  - Page 8 (Mental Status)



# 5 Axis Diagnosis

---

- Axis I:
  - Clinical Disorders
  - Other Conditions that may be a focus of Clinical Attention
- Axis II:
  - Personality Disorders
  - Mental Retardation
- Axis III:
  - General Medical Conditions
- Axis IV:
  - Psychosocial and Environmental Problems
- Axis V:
  - Global Assessment of Functioning



# 5 Axis Diagnosis

---

- ❑ The diagnosis must be a complete 5-axis diagnosis
- ❑ Services/interventions for Medi-Cal must be directed towards an “included” diagnosis except for initial contacts during the evaluation process or crisis services
  - The diagnosis which services/interventions are directed towards, should be listed as the Primary Diagnosis in the Clinical Record and in the IS because this will be the diagnosis associated with a claim.
    - ❑ Having another diagnosis that is not “included” does not exclude a client from having his/her services reimbursed
      - Excluded diagnoses can be listed as a Secondary Diagnosis



# 5 Axis Diagnosis

---

- Rule Outs do not get entered into the IS
  - Should be noted under the appropriate Axis as "R/O xxxx" without an associated code
- Axis should be left blank if there is no diagnosis on that Axis





# DIAGNOSIS

---

- ❑ The diagnosis must be a complete 5-axis diagnosis
- ❑ Services/interventions for Medi-Cal must be directed towards an “included” diagnosis except for initial contacts during the evaluation process or crisis services
  - The diagnosis which services/interventions are directed towards, should be listed as the Primary Diagnosis in the Clinical Record and in the IS because this will be the diagnosis associated with a claim.
    - ❑ Having another diagnosis that is not “included” does not exclude a client from having his/her services reimbursed
      - Example of an included diagnosis includes Major Depressive Disorder
      - Example of an excluded diagnosis includes Polysubstance Dependence
        - Excluded diagnoses can be listed as a Secondary Diagnosis



# DIAGNOSIS

---

- When an episode is originally opened, it may not be clear what diagnosis is appropriate due to the need to gather additional information or complete the full Assessment.
  - If impairments can be identified and “No Medical Necessity” has not been ascertained, the episode may be opened with a “799.9 Deferred Diagnosis” on Axis I.
    - An Episode cannot be closed with a “Deferred Diagnosis.” It may be closed with “V71.09 No Diagnosis” on Axis I.
  - As soon as a diagnosis is determined, both the clinical record and the IS must be updated with the correct diagnosis
- The diagnosis should only be documented on the Initial Assessment and/or Diagnosis Information form
  - Any time a diagnosis is added, changed, or no longer appropriate for a client a “Diagnosis Information” form MH 501 must be completed



# DIAGNOSIS

---

- Things to watch out for:
  - Discrepancies in Diagnosis
    - i.e. MD has one diagnosis and clinician has another
  
- Exceptions to Included Diagnosis Requirement:
  - PEI or other MHSA programs



# 5 Axis Diagnosis

---

- Documented on AIA
  - Page 5 Section IX (Summary and Diagnosis) – Admission Diagnosis

- Documented on CAIA
  - Page 9 (Summary and Diagnosis) – Admission Diagnosis



# Additional Points to Remember

---

- If information was documented elsewhere, there is no need to re-write it
  - Refer to where it is written
  
- Under “Summary and Diagnosis”
  - “Above Diagnosis From” is for situations in which you are basing a dx off of another provider’s dx
  - Co-Signature is only required if the Assessor is a student or the Agency has its own standard for requiring co-signature



# Additional Points to Remember

---

- ❑ Must include a clear reason for referral, signs and symptoms that support the diagnosis, and the severity of impairment within the client's setting (work, school, community)
- ❑ Documenting client's previous functioning helps determine where you are trying to get the client back to



# Assessment Summary

---

- ❑ The Assessment is the first step in the Clinical Loop and lays the foundation for the Client Care Coordination Plan and the Progress Notes
- ❑ A thorough, clearly documented Assessment is vital in assisting other staff in claiming for services provided to a client



# Resources

---

- Your Supervisor or Program Manager
- Clinical Forms
  - <http://dmh.lacounty.gov/Forms.asp>
- Organizational Provider's Manual
  - [http://dmh.lacounty.gov/Agency\\_Admin.asp](http://dmh.lacounty.gov/Agency_Admin.asp)
- Procedure Codes Guide
  - [http://dmh.lacounty.gov/Agency\\_Admin.asp](http://dmh.lacounty.gov/Agency_Admin.asp)
- IS Codes Manual
  - <http://dmh.lacounty.gov/hipaa/index.html>

