West Michigan wmCMH	**Screening and Initial Assessment Procedures**			
	Chapter:	Board Service and Program Administration	**Policy #**	2-6-1
	Section:	Service Coordination	**Revision #**	5

I. **PURPOSE:** To establish policy and procedures for the implementation of a single entry (Access) assessment system.

II. **APPLICATION:** All mental health programs and services operated by the West Michigan Community Mental Health Governing Body.

III. **REQUIRED BY:** Accrediting Bodies, Michigan Mental Health Code, and P. A. 258 of 1974, as amended.

IV. **DEFINITIONS:**

1. Access: Access functions as the point of single entry/eligibility determination for all behavioral healthcare services provided by West Michigan Community Mental Health and its contracted network providers. The Access Team provides a thorough, clinically relevant screening and assessment using valid, reliable, and standardized tools, which results in an appropriate internal or external referral to address the issue which prompted the call to CMH. The program utilizes standardized methodology and clinical guidelines to identify appropriate levels of care and services. The Access Team is responsible for appropriate follow-up on all referrals.

   Access is to provide the people we serve with easy and timely access to services and community resources. When appropriate, a screening/assessment may take place at a secure off-site location. Note: When additional assessments are needed for differential diagnosis or for consideration of additional interventions/ supports, these will typically be completed before referral to the program. All persons being referred to the program for continued services will begin orientation to the program. Please see policy Section 2: Assessment, Service Planning and Documentation, Subject Service Planning, Documentation and Case Coordination.

2. Eligibility Criteria: Eligibility Criteria are taken directly from the Michigan Department of Health and Human Services Medicaid Provider Manual and/or related MDHHS approved published guidelines.

3. Eligibility Determination: This function is completed by the Access Screening/ Assessment and the provider network intake assessment process. Eligibility determination is the process of ensuring that the persons served meet criteria as set forth in the Michigan Medicaid Manual and contract obligations with the State of Michigan Department of Health and Human Services.

4. Preliminary Plan: The Preliminary Plan of Service directs the services provided prior to the Person-Centered Plan completion. This plan is developed at Access and is signed by the person served. The Preliminary Plan of Service is to expire within 30 days of completion.

5. Timeframes of Level of Care Assessments:

   5.1 Routine: Stated symptoms or observed behavior suggesting the presence of a psychiatric or developmental disability with minimal impact on life domains, and

without foreseeable risk of harm to self or others. Routine requests are seen within 14 calendar days/10 business days of the initial request for service.

5.2 Urgent: Presenting behavioral health care problem/developmental disability is impeding the individual from functioning in two or more life domains of personal functioning: work or school; socially or in interpersonal relationships; within the family; and/or intra-personal or in care of self, etc.; suggesting a moderate level of risk and/or others. Urgent requests are seen within 3 hours of the initial request for service.

5.3 Emergency: Stated or observed behavior demonstrating an imminent risk of harm to self or others due to a psychiatric or developmental disability. Emergency requests are seen immediately and/or are resolved within 3 hours of the request for service. Priority population for SUD are screened and referred within 24 hours.

6. Person Served: An individual requesting or currently receiving CMH services, or a third party, such as law enforcement, a guardian, custodial parent of a minor, a family member, or a representative from a foster home, hospital or nursing facility requesting CMH services for a person in its care.

7. Informed Consent for CMH Assessment Services: Written authorization of a person served, or a parent of a minor or guardian, authorizing the individual's participation in CMH services based upon:

   7.1 Comprehension, which is the ability to rationally understand what the personal implications of providing consent, will be based upon adequate information provided to the individual
   7.2 Knowledge, which is adequate information to permit an informed consent; and
   7.3 Voluntariness, which means no element of force, fraud, deceit, or coercion used to obtain the written informed consent.

8. Consultation: An exchange of information with another identified entity on behalf of the person served, which may include history, assessment information, diagnostic impression and recommendations. Consultation requires an informed written consent by the person served or their court appointed guardian, or custodial parent of a minor, and includes the specific information to be shared. CMH staff members shall verbally inform the person (or parent of a minor or empowered guardian) who is the subject of the requested consultation of the following:

   a. Who (community agency/service provider) requested the consultation;
   b. The identified reason for the requested consultation;
   c. CMH policy regarding confidentiality and disclosure of customer related information; and
   d. The time period in which the information is to be exchanged.

9. Referral: The process of receiving referrals from other community care providers or referring an individual to an appropriate service provider as determined by assessment/screening, with consent of the individual, parent or empowered guardian.

10. Electronic Clinical Record/Screening: A computerized documentation system used to record single entry data. All requests for CMH services are documented in the Electronic Clinical Record screening. The following data is recorded and maintained:

    a. Unique screening number;
    b. Indication of a new request, or a request from a previous customer;
    c. Name of person served, address, phone number, date of birth, and service requested;
    d. Date of request;
    e. Date of scheduled assessment and name of the assessment clinician;
    f. Internal/External referral information;
    g. Third party triage or screening information. (i.e. crisis center, ProtoCall® report)
    h. Presenting problem/mental status/assessment of needs
    i. Disposition of those referred out, etc. identification of choices available for community resources;
    j. Insurance information;
    k. Name of primary care physician; and
    l. Current medications.

V. **POLICY:** It is the policy of the West Michigan Community Mental Health to implement and maintain a single entry assessment and referral system.

VI. **PROCEDURES:**

1. Screening process and crisis intervention services are available to all Michigan or out of state residents and are not restricted to individuals who have a residence within the catchment area of WMCMH.

2. Access staff are welcoming, accepting, and helping with all applicants for service.

3. Special access needs of all individuals are assessed, and accommodations are made when necessary to ensure barrier free access to care.

4. Screening for service eligibility is provided without charge to individuals and do not require authorization.

5. Access provides access to care 24 hours a day, seven days per week. (Please note: A qualified practitioner is always immediately available by phone or in person to respond to the crisis/emergent needs of an individual without requiring a call back).

6. The telephone response system is answered by a live voice demonstrating a welcoming atmosphere.

7. Routine walk-in requests are received on a first come first serve basis in all three counties during normal business hours. All persons served who are triaged “non-emergent” will not be asked to wait no longer than 30 minutes for screening or other arrangements to be made.

8. Routine telephone requests will not be put on hold for more than 3 minutes and if a

callback is required it will occur within one business day.

9. The Chief Healthcare Integration Officer/designee shall be responsible for the single-entry screening/ assessment and referral system as well as any waiting list the agency may have.

10. All persons requesting services shall be assigned a case number and be tracked through the electronic medical record.

11. Assigned, qualified, and appropriately trained clinicians shall be responsible for completing the screening/assessment for all individuals seeking or being referred for community mental health/substance use disorder treatment services. Prior to the initiation of the assessment, the person served, guardian or parent will sign an informed consent for assessment/treatment.

12. Assigned, qualified, and appropriately trained clinician will actively seek and include information in the screening / assessment from the person served, family members or legal guardians when permitted, and any other appropriate collateral source.

13. Prior to determination of eligibility for publicly funded mental health/substance use disorder treatment services, every person served is given the opportunity, with guidance and support, to describe their experiences and identify their needs in their own terms.

14. Brief Behavioral Health Screening to Determine Eligibility; Access shall determine if the individual meets eligibility criteria as set forth in the Michigan Medicaid Manual Eligibility also considers the entitlements of the CCBHC Provider Status, Medicaid Specialty Supports Program and managing the General Fund Population, and Healthy Michigan programs as primary service populations.

    a. Services are provided to individuals who have a serious mental illness, serious emotional disturbance, developmental disability, mild to moderate mental health disorders, and/or substance use disorders and resulting functional impairments from these issues.
    b. Priority is given to those individuals with the most severe forms of mental illness, serious emotional disturbance, developmental disability, and substance use disorders and those in urgent and emergent situations.
    c. WMCMH shall provide mental health services to persons enrolled in the Healthy Michigan Program as required by the MDHHS/PIHP Managed Mental Health Services and Supports Contract, who have other mental disorders that meet criteria specified in the most recent *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association (DSM).
    d. WMCMH may provide mental health services to non-Medicaid individuals who have other mental disorders that meet the criteria specified in the most recent DSM.
    e. WMCMH/Access shall not deny an eligible individual any medically necessary mental health service due to individual/family income, third party payer source, or because the individual/family is financially liable and unable to pay for the service, or residency status.
    f. WMCMH provides Outpatient SUD Treatment Services to individuals who

meet medical necessity requirement, those with commercial insurances, and those who pay for their own services. WMCMH General Fund may not be allocated to these services, therefore, when individuals do not qualify for existing funding assistance, payment for services is the responsibility of the individual when not covered by other available SUD funding. WMCMH also provides Mild/Moderate services to certain Medicaid Health Plans; however, General Fund may not be allocated for this service. CCBHC funds may be used to fund services, as allowed.

15. Crisis Intervention:

    a. The Crisis Stabilization Services (CSS) Program provides/manages the emergency on call services to the community, in which Access may provide services. These services include in person and/or telephonic DBT Coaching, Mobile Crisis Services, and Pre-admission Screenings to determine whether inpatient hospitalization is necessary. The goal is to quickly stabilize the individual/family and to prevent a more serious crisis and/or need. The crisis intervention leads to an initial crisis intervention plan, in consultation with any/all available supports, which includes identified immediate response needs, appropriate follow when a referral is made, and a statement of the crisis resolution. When children are the identified consumer, then the crisis stabilization is provided to the family as a unit.
    b. ProtoCall Services, Inc. provides crisis phone answering, triage, and screening services on behalf of the Access Department. ProtoCall screens requests for services by phone and provides Access with its completed screenings for follow up by Access. Requests that are determined to be an emergency are immediately referred to Access for follow-up services through direct notification. ProtoCall and Access staff determine the status of each request, routine, urgent or emergency. Note: When appropriate, a screening/assessment may take place at a secure off-site location. If Access is unable to complete the initial assessment, a provider program will be called upon for assistance in completing the assessment on a face-to-face basis at a provider location, or off-site location, whichever is most convenient for the person served.
    c. The individual phoning in for services implies consent for treatment.
    d. Requests may be made from other providers for a mental health consultation. For these requests, the person served must still consent to the assessment prior to mental health's involvement. If the person served decides against the assessment, the identified recipient of record is the requesting agency.

16. Initial Intake Assessment:

    a. The initial assessment process for both mental health and SUD services will gather sufficient information including but not limited to; presenting problem(s), needs, strengths, preferences, abilities and interests, information regarding previous behavioral health services, physical health history and current medical needs, any co-occurring disabilities or disorders, evidence or history of trauma, abuse or domestic violence, current legal issues or status, mental status, diagnosis, current level of functioning, use of drugs or alcohol, issues important to the person, need for supports, need for accommodations

in the provision of services, risk taking behaviors including suicide risk, education level, knowledge of advance directives, medication use, allergies, and an adequate summary based on assessment data which can be adequately used to develop an individualized person-centered plan.

b. Access Clinicians, upon the completion of the intake assessment, are to make a determination of the presenting problem, need for services, severity of dysfunction in the impacted primary life domains (personal, family, work, or societal), diagnostic impression and eligibility criteria for public funded community mental health services. Those persons appearing to meet the Medicaid Manual eligibility and medical necessity criteria are assigned by Access to the most appropriate level of care for the first appointment and services and informed of the person responsible for service coordination. When requested, the program provides a written summary or copy of the assessment and referral to the individual served and/or his or her legal guardian.

17. Orientation and Preliminary Plan: Prior to assigning the person served to a level of care, service entry will complete the first part of the orientation process as well as a preliminary plan of service. When referred to SUD Treatment services a preliminary plan is not completed. The orientation process involves an explanation of the rights and responsibilities of persons served, grievance and appeal procedures, explanation of financial responsibility, achievement of outcomes, satisfaction of the person served, the organization's services and activities, expectations, hours of operation, access to after-hours emergency services, the agency's code of ethics, confidentiality, and follow-up requirements. Brochures are also provided explaining any program rules. For a complete review please see policy Section 2: Assessment, Service Planning and Documentation Subject Service Planning, Documentation and Case Coordination.

18. Prior to the referral to the program, Access staff will ensure the person served has completed a consent and ability to pay form, health and safety questionnaire, and any applicable outcomes scales.

19. Referral:
    a. Access Clinicians shall place the first appointment in the appropriate level of care in the Clinical Service Planner (CSP) or appropriate clinician's schedule and provide any appropriate staffing.
    b. Access Assessment will identify the provider program and authorization for that service. The assigned level of care responsible case holder authorized to complete the service is responsible for completing the program orientation with the person served and others as identified by the person served, such as advocates, concerned family members, or friends.
    c. Access shall notify the level of care clinician if there are any specific insurance limitations/requirements. For instance, the insurance company of the person served may require services be provided by a specific mental health professional; fully licensed/limited licensed psychologist, licensed social worker, licensed professional counselor, etc. The Access Clinician will also seek out and obtain any prior authorization from the private insurance company for service that may be required.
    d. As required by some insurances, Access Clinicians will refer for and coordinate

the completion of a physical exam by a physician within the required timeframes. An example of one such requirement is that persons admitted to Outpatient SUD Treatment covered in whole or in part by BCBS insurance shall complete a physical examination with a physician within 3 weeks from their first clinical contact with CMH.

20. For a complete review of the documentation and consumer flow following the Access Assessment into services, please see policy Section 2: Assessment, Service Planning and Documentation Subject Service Planning, Documentation and Case Coordination.

21. When a person is found ineligible for services from Community Mental Health, the person is informed as to the reasons, the referral source (with the consent of the person served) is informed of the reasons, and recommendations are made for alternative services or resources. The person served is asked to sign a release of information so the Access Clinician could expedite a referral to the community referral source by sending a copy of the completed assessment. The person served is also given written Notice of Benefit Determination describing the ineligible service and reason for denial informing the person served of their rights when service is denied.

22. Follow-up: Upon either internal or external referrals, the Access Clinician will conduct appropriate follow-up with the person served. For external referrals, follow up will be done via phone with documentation in the progress note in the EMR. For internal referrals, follow up will be in consultation with the CMH and documentation in the clinical file. The outcome of the follow up is to achieve the following:

    a. To ensure linkage to the referral.
    b. To follow-up on additional care that may be needed.
    c. To assist in further treatment planning as needed.
    d. To encourage and support the person served in their individual recovery plan.

23. Waiting List: WMCMH/Access shall develop, maintain, and utilize a waiting list if it cannot meet the needs of its priority populations, as identified above.

    a. WMCMH/Access shall ensure that all Medicaid and Healthy Michigan beneficiaries immediately access and receive any medically necessary service, in accordance with the timeframes established by MDHHS.
    b. WMCMH/Access, when necessary, shall maintain a waiting list log for any non-Medicaid or Healthy Michigan individual with a serious mental illness, serious emotional disturbance, developmental disability, or substance use disorder who is unable to access any non-Medicaid/non-entitlement program or services/supports.

    c. The waiting list will document the individual's needs and length of time on the list.
    d. The waiting list will be continually reviewed and updated.
    e. Contact with individuals on the list will be based on each person's needs and well documented in the electronic clinic record.
    f. Any individual, regardless of payment source, needing emergent, medically

necessary care shall not be placed on any waiting list. They will be immediately served and if needed, referred to a secure location and medical or law enforcement personnel may be asked to assist.

g. WMCMH/Access shall maintain a waiting list for specific program services for individuals without Medicaid or any other form of insurance with a serious mental illness, serious emotional disturbance, developmental disability, or substance use disorder service who cannot access a medically necessary service but is offered a less intensive service(s) on an interim basis.
h. WMCMH/Access shall submit written waiting list documentation to MDHHS or any priority population defined in Section C.8.8 above and is not provided the medically necessary service within 120 days of program request.
i. WMCMH/Access shall prioritize service to persons on its waiting list whose functional impairment is most severe.
j. WMCMH/Access shall contact and follow-up with any person on a waiting list either awaiting system access or a medically necessary service at a minimum of once per week as documented in the electronic clinical record.
k. When resources permit, interim or alternative services shall be offered, as appropriate, to persons on the waiting list.

24. Second Opinion

a. If a person served/applicant requesting services has been denied mental health services, the WMCMH/Access or designee shall notify the applicant, his or her guardian, or the minor applicant's parent(s) that a second opinion may be requested. The chief executive officer or designee shall secure the second opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level psychologist. The request shall be processed in compliance with Section 705 of the Code and must be resolved within five business days.
b. If the individual providing the second opinion determines that the applicant has a serious mental illness, serious emotional disturbance, a developmental disability, or is experiencing an emergency situation, or urgent situation, the community mental health services program shall direct services to the applicant.

VII. **SUPPORTING DOCUMENTS:** NQC_QI_F_12 Priority Population Guidelines

VIII. POLICY/PROCEDURES REVIEW:

REV#	APPROVED BY	Policy/Procedure	DATE
			11/2009
			03/2010
			03/2011
			12/2011
			06/2014
			02/2016
			02/2017
			01/2019
			10/2019
NC	COC	Procedure	05/2021

3	COC	Procedure	04/2022
3	COC	Annual Review	03/2023
4	COC	Procedure	03/2024
5	COC	Definitions	05/2024
***Board Approval Date**: 02/20/1996*			

IX. **CHIEF EXECUTIVE OFFICER ENDORSEMENT**:

I have reviewed and approve of policy # 2-6-1 Revision # 5.

CEO: Lisa A. Williams **Approval Signature: _____**