DMAS/DBHDS Comprehensive Needs Assessment Comparison

11-27-18

DMAS Comprehensive Needs Assessment Requirements: 15 Elements	**DBHBDS – Initial Assessment/Comprehensive Assessment Requirements** **Italicized and Underlined* = Initial Assessment Requirements ***Bold** = items DBHDS requires that are not required by DMAS, list is not inclusive of all differences. Providers are responsible for ensuring compliance with DBHDS requirements. *Please note that the following DBHDS timelines of completion of assessments ✓ Initial Assessment (VAC12VAC35-105-650.E) states: "An assessment shall be initiated prior to or at admission to the service" ✓ Comprehensive Assessment (VAC12VAC35-105-650.F) states: "A comprehensive assessment shall update and finalize the initial assessment. The timing for completion of the comprehensive assessment shall be based upon the nature and scope of the service but shall occur no later than 30 days**, after** admission for providers of mental health and substance abuse services…" "A provider can meet the regulations by completing a comprehensive assessment covering all elements in the initial assessment requirements (VAC12VAC35-105-650.E) and the comprehensive assessment (VAC12VAC35-105-650.F) if the provider completes an addendum "updating and finalizing the initial assessment" within 30 days after admission".

DMAS	DBHDS
1. **Presenting Issue(s)/Reason for Referral: Chief Complaint**. ✓ Indicate duration, frequency and severity of behavioral health symptoms. Identify precipitating events/stressors, relevant history.) If a child is at risk of an out of home placement, state the specific reason and what the out-of-home placement may be.	_*Presenting needs*_ ✓ including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems; ✓ Onset and duration of problems
2. **Behavioral Health History/Hospitalizations:** ✓ Give details of mental health history and any mental health related hospitalizations and diagnoses. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.	✓ Previous interventions and outcomes; ✓ Diagnosis
3. Previous Interventions by providers and timeframes and response to treatment: ✓ include the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider.	✓ Previous interventions and outcomes
4. **Medical Profile:** ✓ Describe significant past and present medical problems, illnesses and injuries, known allergies, current physical complaints and medications. ✓ As needed, conduct an individualized fall risk assessment to indicate whether the individual has any physical conditions or other impairments that put her or him at risk for falling. All children aged 10 years or younger should be assessed for fall risks based on age-specific	✓ _*Current Medical problems*_ ✓ _*Current medications*_ ✓ **As applicable, and in all residential services, fall risk, communication methods or needs, and mobility and adaptive equipment needs.** ✓ Health history and current medical care needs, to include:

norms.	a. Allergies; b. Recent physical complaints and medical conditions; c. Nutritional needs; d. Chronic conditions; e. Communicable diseases; f. Restrictions on physical activities if any; **g. Restrictive protocols or special supervision requirements;** h. Past serious illnesses, serious injuries, and hospitalizations; i. Serious illnesses and chronic conditions of the individual's parents, siblings, and significant others in the same household; and
5. **Developmental History:** ✓ Describe the individual as an infant and as a toddler: individual's typical affect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and the parent's ability to provide these; parent's feelings/thoughts about individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones, if so, describe. Were there any significant complications at birth?	✓ Social, behavioral, developmental, and family history and supports; ✓ **History of abuse, neglect, sexual, or domestic violence, or trauma including psychological trauma;** ✓ **cognitive functioning including strengths and weaknesses**
6. **Educational/Vocational Status:** ✓ School, grade, special education/IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, and peer relationships.	✓ **Financial resources and benefits** ✓ Employment, vocational, and educational background

7. **Current Living Situation, Family History and Relationships:** ✓ Describe the daily routine and structure, housing arrangements, financial resources and benefits. ✓ Significant family history including family conflicts, relationships and interactions affecting the individual and family's functioning should be listed along with a list of all family or household members.	✓ Social, behavioral, developmental, and family history and supports; ✓ Housing arrangements;
8. **Legal Status: Indicate individual's criminal justice status.** ✓ Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations.	✓ Legal status **including authorized representative, commitment, and representative payee status;** ✓ Relevant criminal charges or convictions and probation or parole status;
9. **Drug and Alcohol Profile:** ✓ Describe substance use by the individual and/or family members; specify the type of substance with frequency and duration of usage. ✓ Include any treatment or other recovery related efforts.	✓ Current and past substance use including alcohol, prescription and nonprescription medications, and illicit drugs ✓ *Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse,* and circumstances that increase the individual's risk for mental health or substance use issues;
10. **Resources and Strengths:** ✓ Document individual's strengths, preferences, extracurricular, community and social activities, extended family; activities that the individual engages in or are meaningful to the individual. These elements are key to developing an ISP that supports the individual's recovery and resiliency efforts and goals.	✓ **Daily living skills** ✓ **Ability to access services including transportation needs**
11. **Mental Status Profile:** ✓ Include findings and clinical tools used.	✓ ***At-risk behavior to self and others.***

12. **Diagnosis:** ✓ The documentation of a diagnosis must include the DSM diagnostic code & description as documented by the LMHP that provided the diagnosis.	✓ *Diagnosis* ✓ Cognitive functioning including strengths and weaknesses;
13. Professional Comprehensive Needs Assessment Summary and Clinical Formulation: ✓ Includes a documentation of medically necessary services as defined by the service provider which: a. Identifies as much as possible, the causes of presenting treatment issues, and b. Identifies and discusses treatment options, outcomes, and potential barriers to progress, so that an individual specific service plan can be developed.	✓ Psychiatric and substance use issues including current mental health or substance use needs, presence of co-occurring disorders, history of substance use or abuse, and circumstances that increase the individual's risk for mental health or substance use issues ✓ Onset and duration of problems ✓ *Presenting needs including the individual's stated needs, psychiatric needs, support needs, and the onset and duration of problems;* ✓ 12VAC35-105-660.B : The provider shall develop an initial person-centered ISP . . . . for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first.
14. **Recommended Care and Treatment Goals**	✓ 12VAC35-105-660.B : The provider shall develop an initial person-centered ISP . . . . for the first 30 days for mental health and substance abuse services. This ISP shall be developed and implemented within 24 hours of admission to address immediate service, health, and safety needs and shall continue in effect until the ISP is developed or the individual is discharged, whichever comes first.
15. Dated signature of the LMHP, LMHP-R, LMHP-RP or LMHP-S.	✓ 12VAC35-105-590.C.4: Supervision shall include responsibility for approving assessments and individualized services plans, as appropriate. This responsibility may be delegated to an employee or contractor who

	meets the qualification for supervision as defined in this section. ✓ 12VAC35-105-590.C.5: Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions.