Comprehensive Assessment Update - Adult Version

This form has been designed to reduce provider agency risks and to save time. It provides a standard and efficient format for updating diagnostic information, re-admitting the Individual served (according to agency policy and procedures), and/or updating the clinical formulation and treatment recommendations. This new/additional information, which is often not easily identifiable in progress notes, creates audit risks for provider agencies. It must be clear to auditors how assessed needs, treatment recommendations, and treatment are linked, especially when the information in the diagnostic assessment is outdated.

This form does not replace initial evaluations or assessments.

It is recommended that this form be kept in date order in the assessment portion of the Individual's record. In all cases, provider agencies should determine whether the new/additional information contained in this form requires an updated diagnosis and/or Individualized Action Plan (IAP) to be completed.

This form can be used whenever the provider believes that significant information (as described above) should be included in the medical record. Some organizations may want to routinely require updates on an annual basis, or when the Individual returns to care within a fairly short time period, or when the Individual changes level of care. Completion of a Comprehensive Assessment Update form does not necessarily assume billing of a diagnostic assessment service. For example, data obtained during an individual therapy session that constitutes important new assessment information can be recorded on the Comprehensive Assessment Update while the service itself would be documented and billed as an Individual Therapy session.

Data Field	Identifying Information
Organization and Program Name	Record the names of the Organization and the Program if applicable
Individual's Name	Record the first name, last name, and middle initial of the Individual being served. Order of name is at agency discretion.
Record #	Record your agency's established Record number for the Individual.
Date of Birth	Record the date of birth of the Individual. **(e.g. MM/DD/YYYY)**
Data Field	**Reason for Update**
Update of New Information, Re-Admission, Periodic Update	Check the appropriate box to indicate whether the Update is: • To Update New information such as new diagnosis and /or assessed needs. • A Re-Admission Update for an individual who left services and has returned to services within a relatively short amount of time (the specific time frame/criteria for use of this form will be left up to each individual agency and their respective policies and procedures). • A Periodic Update as determined by agency policy/program regulations. Also, indicate date of Admission. Date of the last Comprehensive Assessment –Record the date of the last Comprehensive Assessment that was completed and is contained in the medical record.

Data Field	Adult Comprehensive Assessment Sections
Adult Comprehensive Assessment Sections	Check all applicable boxes next to the section(s) of the Comprehensive Assessment being updated. All information being updated must be labeled with the corresponding number to indicate which section is being updated (i.e., if one was updating medication information, he/she would write #13 in the narrative section and provide information).Updates may require an IAP Revision or a new IAP if there are changes to treatment including goals, objectives, interventions and services offered.
Data Field	**Update Narrative**
Update Narrative	Provide a narrative explanation for each box selected in the section above. Indicate number which corresponds to each section being updated.
Data Field	**Screening Tools?**
Was any evidence-based screening tool(s) administered?	Specify if any screening tools were utilized to help assess the Individual's functioning. For example, as a result of efforts by both OASAS and OMH, various screening tools have been identified to help identify co-morbidities (e.g. substance use/mental health) and support the goal of integrated treatment. Recommended tools for mental health screening include: Modified Mini Screen (MMS); Mental Health Screening Form III (MHSF-III); and K-6 (Kessler). Recommended tools for substance use screening include: Modified Simple Screening Instrument for Substance Abuse (MSSI-SA); CAGE-AID; and ASSIST. Other tools can be utilized as per agency's policy/direction.
Data Field	**Diagnosis**
Diagnosis	Check No Change, if the update does not result in a change in diagnosis. If there is any change or addition to the diagnosis, this section should be used to record a full diagnostic picture with keeping the following in mind: Record all current, active diagnoses (including changed diagnoses) that will provide support for the medical necessity of the services that will be provided for the Individual. The diagnoses can be recorded in either ICD-9 CM codes and narrative or DSM codes and narrative. Check the appropriate box at the top of this section to indicate if you are using ICD or DSM codes. **ICD-9 CM Codes:** List codes in appropriate order using ICD coding conventions. List next to each code the narrative description of the code from the ICD-9 CM code book. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode. **DSM Diagnostic Codes:** List codes next to appropriate Axis designation using DSM coding conventions. All five axes can be recorded in this section. Next to the codes list their narrative description from the DSM code book. All five diagnoses can be recorded on the document. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode. **Note:** Providers should ensure familiarity with regulations governing who can diagnose mental illness and adhere to state licensing laws as applicable.

Data Field	Individual Served/Family/ Guardian Expression of Service Preferences
Service Preferences	It is important that the clinician engage in a meaningful recovery focused dialogue with the Individual (and/or primary support Individual) which allows the Individual (and/or primary support person) to express his/her desired treatment, support preferences, and priorities. Record the prioritized service preferences for the full range of behavioral health and community-based rehabilitative services, and environmental support services available, as identified by the Individual (and others involved with the Individual) based on the areas covered in the Assessed Needs. Include the Individual's preferences to develop or have available additional natural and community supports, as a part of his/her Recovery Process. If applicable to the Individual, discuss peer support, family education, other support, housing, transportation, social opportunities, and community involvement. Identify available resources. Discuss the Individual's preferences for activities focused on reducing prejudice and discrimination against him/her and/or increasing his/her power and control over his/her life and future.
Data Field	**Treatment Recommendations**
Treatment Recommendations / Assessed Needs	If, upon review of the most recent Adult Comprehensive Assessment and the information from this update there are no additional recommendations or assessed needs, check the box **No Additional Recommendations Clinically Indicated**. If there are additional Treatment Recommendations/Assessed Needs, the clinician, Individual served and others involved with the Individual, including family as appropriate, should collaborate to identify and prioritize needs. These identified needs should be considered as the basis for subsequent treatment goals and/or objectives and all should be geared to improving the functioning of the Individual or reducing his or her signs and symptoms. (See instructions for Comprehensive Assessment for examples of Prioritized Assessed Needs.) To the right of each identified need check the appropriate box indicating whether the need is "Active" (i.e. will be addressed in the IAP), "Person Declined" (i.e. the individual chooses not to address this need at this time), "Deferred" (i.e. the Individual and clinician have determined not to address the need until a later time), or "referred" (i.e. the need requires referral to another program, service, or practitioner). In some cases there may be high need areas that cannot be declined or deferred without risk to the individual and must stay on the list as a treatment need. These should be the exceptions to the person-centeredness of this negotiation.
Data Field	**Individual Declined/Deferred/Referred**
Individual Declined/Deferred/Referred Out Rationale(s)	Describe reasoning behind worker's decisions to defer or refer out work on any assessed needs. Also provide reasoning behind decisions by individual served to decline a recommendation at this time.
Data Field	**Further Evaluations Needed**
Further Evaluations Needed	Check the boxes that identify additional assessments needed for the Individual (if any).

Data Field	Level of Care/Indicated Services Recommendation
Level of Care/ Indicated Services Recommendation	Recommend and record the least restrictive level of care that is safe for the Individual based upon his or her current clinical presentation. This recommendation needs to be strongly supported by the symptoms, behaviors, skill deficits and abilities documented in the earlier sections of the comprehensive assessment or this update. The Level of Care should be directly linked to medical necessity which should be evidenced by the documentation throughout the assessment. Also, indicate the services that can be utilized within each Level of Care to meet the identified clinical needs and the service preferences provided by the Individual/family. **Example: Outpatient Level of Care with emphasis on Community Support, Individual Therapy and medication management Services.** If there is no change to the Level of Care/Indicated Services Recommendation, check the "No Change" box.
Data Field	**Individual Served/Guardian Family Response to Recommendations**
Individual Served/Guardian Family Response to Recommendations	Describe the individual's/family's response to the treatment recommendations.
Data Field	**Treatment Planning Updates**
Change In IAP Required	If the newly identified assessed therapeutic needs can be supported by the Goals, Objectives, Interventions, services, frequency, duration and responsible provider(s) in the current IAP, then an IAP Revision is not required. If the assessed treatment needs cannot be supported by the current IAP, then a change in the IAP is required (revision or completion of new IAP). Please indicate the change by completing the appropriate form.
Data Field	**Signatures**
Provider - Print Name, Credential, Signature, and Date	Legibly print name and record legible signature of the clinician completing the assessment update. Record the educational level/highest license level of the clinician completing the assessment. Record the signature date.
Supervisor- Print Name, Credential, and provide signature (If needed)	Legibly print name and record legible signature of the supervisor reviewing the assessment update. Record the educational level/highest license level of the supervisor reviewing the assessment. Record the signature date.
Psychiatrist-Print Name, Credential and provide signature (if needed)	Legibly print name and record legible signature of the Psychiatrist reviewing the assessment. Record the educational level/highest license level of the Psychiatrist reviewing the assessment. Record the signature date.