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 persons 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treatment recommendations and treatment are linked, especially when the information in the diagnostic assessment is outdated.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 diagnostic assessment portion of the person's record. In all cases, provider agencies should determine whether the new/additional information contained in this form requires an updated Individualized Action Plan (IAP) to be completed.

This form can be used whenever the provider believes that updated diagnostic information should be included in the medical record. Some organizations may want to routinely require updates on an annual basis, or when the person returns to care within a fairly short time period, or when the person changes level of care. This form does not replace existing formats for original evaluations/assessments. 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 have been documented and billed as Individual Therapy.

Data Field	Identifying Information
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record the date of admission per agency policy (this should be the first service date for this service episode).
Organization/Program Name	Record the organization and program to which you are delivering the service.
DOB	Record the person's date of birth
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
Data Field	**Section I: Reason for Update**
Annual Update, Re-Admission and Interim Update of New Information	Check the appropriate box to indicate whether the Update is: • an Annual Update of the Comprehensive Assessment (if required by agency policy and procedures and/or accreditation), • a Re-Admission Update for a person who left services and has returned to services within one year of the date of the last Comprehensive Assessment in the health record, or • an Interim Update of New Information while the person is in service that provides a therapeutic basis for additional services. Refer to the introduction above for clarification of each type of indicator.
Data Field	**Date of Original CA and Sections**
Date of Most Recent Comprehensive Assessment	Enter the date of the last Comprehensive Assessment in the chart
Adult Comprehensive	Check all applicable boxes next to the section(s) of the Comprehensive Assessment

Assessment Sections for Update	being updated. All additional information being updated must be labeled in the narrative section of this form with the Comprehensive Assessment section heading. * Updates may require an IAP Revision or a new IAP. Annual Updates and Re-Admissions may require a new IAP if there are changes to treatment including goals, objectives and services offered.
Data Field	**Update Narrative**
Update Narrative	Provide a narrative explanation for each box selected in the section above. List each as a separate heading and write the narrative below.
Signature/Credentials (if Licensed Clinician did not obtain the information above)	If the above sections are completed by an unlicensed staff person (e.g., unlicensed clinician, CSP Outreach Worker), the person completing these sections signs here and adds his or her credentials. *The remainder of this document must be completed by a licensed clinician who will sign in the box below and again at the bottom of the completed document.
Date	Enter date the unlicensed staff completed and signed Section I.
Data Field	**ASAM Degree of Severity at Admission for the Following Dimensions (SU Persons served only)**
Dimension	The following websites provide additional information on the use of the ASAM matrix: http://www.asam.org/PatientPlacementCriteria.html http://mass.gov/dph/bsas http://www.neias.org/
Intoxication/Withdrawal Potential	Record severity on a scale of 0 (None) to 4 (Severe)
Biomedical Conditions/Complications	Record severity on a scale of 0 (None) to 4 (Severe)
Emotional/Behavioral/ Cognitive	Record severity on a scale of 0 (None) to 4 (Severe)
Readiness to Change	Record severity on a scale of 0 (None) to 4 (Severe)
Relapse/ Continued Use Potential	Record severity on a scale of 0 (None) to 4 (Severe)
Recovery Environment	Record severity on a scale of 0 (None) to 4 (Severe)
Family Functioning (Youth Only)	Record severity on a scale of 0 (None) to 4 (Severe)
Data Field	**Section II: Diagnosis Change**
Diagnosis Change- This section must be completed by a qualified provider	If there is any change or addition to the diagnosis, this section should be used to record a full diagnostic picture including any changes to diagnoses using the following instructions. This section is used to record all current diagnoses that will provide the documented support for the medical necessity of services that will be provided for the person. Diagnoses can be recorded in either ICD-10 CM codes and narrative, or DSM codes and narrative. Check the applicable box at the top of the *Diagnosis* section to indicate if you are using ICD or DSM codes. **ICD CM Codes:** Check if using ICD-9 or ICD-10 codes. List codes in appropriate order using ICD-9 or ICD-10 coding conventions. Next to each code, complete a narrative description of the code from the ICD-9 or ICD-10 CM code book. Place a check next to the diagnosis that is the primary diagnosis for this treatment episode. **DSM Diagnostic Codes**: Check if using DSM-IV or DSM 5 codes. List codes using DSM coding conventions. Next to each code, complete a narrative description from the DSM code book. 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.
Check Primary/ Billing Diagnosis	Check the primary/billing diagnosis.
Code	Indicate the ICD or DSM numerical or alphanumerical code.
Narrative Description	List the narrative description of the code in either DSM or ICD terminology.
Data Field	**Person Served/ Family/ Guardian Expression of Service Preferences**
Service Preferences	It is important that the clinician engage in a meaningful recovery focused dialogue with the person (and/or primary support person) which allows the person (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 person (and others involved with the person) based on the areas covered in the Assessed Needs. Include the person's preferences to develop or have available additional natural and community supports, as a part of his/her Recovery Process. If applicable to the person, discuss peer support, family education, other support, housing, transportation, social opportunities, and community involvement. Identify available resources. Discuss the person'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.
No Changes	Check if there have not been changes in service preferences.
Data Field	**Assessed and Prioritized Needs Checklist Including Functional Domains**
Assessed and Prioritized Needs Checklist Including Functional Domains	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, person served and others involved with the person, 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 person or reducing his or her signs and symptoms. **Examples**: • **Decrease symptoms of depression** • **Reduce suicidal ideation** • **Education about illness and treatment options** • **Enhanced management of active symptoms** • **Medication stabilization** • **Reduction of anger episodes** • **Development of symptom management skills**
Person Declined/Deferred/ Referred Out Rationale(s) (Explain why Person Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred or Referred Out)	Describe reasoning behind worker's decisions to defer or refer out work on any assessed needs. Also provide reasoning behind decisions by person served to decline a recommendation at this time.

Data Field	Further Evaluations Needed
Further Evaluations Needed	Check the box(es) that identify additional assessment(s) needed for the person (if any).
Data Field	**Was Outcomes Tool Administered?**
Was outcomes tool administered?	This is an optional field. Providers may choose to or have contract requirements relative to outcomes. Information pertaining to outcomes should be entered in this section. In some cases, the provider may wish to note the name of the instrument and most recent administration. The instrument and results may be located elsewhere in the medical record, however, this information should be used to assist in the development of treatment plan updates.
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Further Evaluations Needed	Check the box(es) that identify additional assessment(s) needed for the person (if any).
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Data Field	**Services and Supports Needed**
Level of Care/ Indicated Services Recommendation	Recommend and record the least restrictive level of care that is safe for the person based upon his or her current clinical presentation. This recommendation needs to be strongly supported by the symptoms, behaviors, skills deficits and abilities/needs documented in the earlier sections of the 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 person/family. ***Adult Outpatient Example:*** Individual outpatient treatment recommended, Every other week. ***CBFS Example:*** Jean would benefit from the assistance of the Richmond Support Housing program to provide her with support in the community while promoting her individual recovery process. If there is no change to the Level of Care/Indicated Services Recommendation, check the "No Change" box.
Data Field	**Response to Recommendations**
Person Served/Guardian/ Family Response to Recommendations	Record person's reactions and opinions to your recommendations in this section. You may record a summary or specific verbal responses provided by the person served/family/guardian. Record the person's and/or family's willingness and ability to participate in treatment. If there was no change to the Level of Care/Indicated Services Recommendation above, check "Not Applicable".
Data Field	**Change in IAP Determination**
Change In IAP Required	If the 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/Review is not required. If the assessed treatment needs cannot be supported by the current IAP, then a change in the IAP is required. Please indicate the change by completing an IAP Revision/Review form.

Data Field	Signatures
Person's Signature (Optional, if clinically appropriate)	If clinically appropriate, record the legible signature of the person served.
Date	Record the date of signature.
Parent/Guardian Signature (if appropriate)	Record legible signature of the person's parent or guardian, if appropriate.
Date	Record the date of signature.
Clinician/ Provider - Print Name/Credential	Legibly print name and record legible signature of the clinician involved in the gathering and completion of the assessment. Record the educational level and the highest license level of the clinician involved in the gathering and completion of the assessment.
Date	Record the date of signature.
Supervisor Print Name/ Credential (If needed)	Legibly print name and record legible signature of the supervisor involved in the gathering and completion of the assessment. Some agencies may have policies requiring supervisor signatures on diagnostic assessments. Record the educational level and the highest license level of the supervisor involved in the gathering and completion of the assessment.
Date	Record the date of signature.
Clinician/Provider Signature	**Legible signature** of person completing the Assessment.
Date	Record the date of signature.
Supervisor Signature (if needed)	If required, legibly record supervisor's signature and credentials.
Date	Record the date of signature.
Psychiatrist/MD/DO Signature (if required)	Record legible signature of the physician involved in the gathering and completion of the assessment, if applicable.
Date	Record the date of signature.
Next Appointment Date/Time	Record the date and time of the person's next appointment.