Intake Assessment: Requirements & Best Practices

Does not include information specific to assessment of minors

The Threefold Purpose of Assessment

1. **Demonstrate medical necessity:**
   This is about insurance. If a client needs treatment, the assessment gives justification. It also demonstrates that a level of care is appropriate. In an outpatient setting, this means that the available information indicates that a client is too unwell to be without treatment but not so unwell that a higher level of care is necessary.
   **This does not mean shaping the assessment to align with an outcome.*

2. **Establish the focus of treatment:**
   The focus is akin to a broadly stated goal; it is always related to the diagnosis.

Diagnosis: Generalized anxiety disorder	Focus: Manage anxiety
Diagnosis: Adjustment disorder	Focus: Cope with [stressor]

3. **Build rapport:**
   The most important objective is to begin forming a relationship, creating a foundation the client will want to return to.

Assessment Topics

This does not describe all assessment components. A few assessment areas are included here with notes.

- **Chief complaint/presenting problem:** This will become the focus of treatment. Include the client's own words in quotes when possible.

- **Suicidal/homicidal ideation: (If yes, risk assessment with protective/supportive factors must be included.)** Passive ideation meets the threshold for requiring risk and protective factors. Here is an example:

  Client endorsed current thoughts of suicide that are passive in nature including, "I want to go be with him," and "I don't know that I want to continue on." She expressly denied actively planning suicide or intending to act on her thoughts. When asked about access to means, she stated, "No, not anymore."

  <u>Risk factors:</u> Recent attempt to die by suicide, death of loved one and corresponding persistent state of intense grief, loneliness and lack of engagement from individuals previously within social circle, and experience of severe depressive symptoms.

  <u>Protective factors:</u> Client is resourceful with access to community support including physical and mental healthcare. Client demonstrates a high level of motivation for therapy. Her son lives with her and she said she feels a positive connection to him. Client demonstrated future orientation through repeated discussion of upcoming appointments. Client also committed to attending a follow up appointment in one week.

- **Trauma history:** Please be mindful of the fact that the assessment is a first encounter.

- **PCP coordination:** Colorado requires that we ask if a client will allow information to be shared with their PCP. If they consent, it's required that we share information, which we limit to diagnosis, presence in treatment, stated treatment needs and the name of the assessing therapist. (Admin team manages.)

- **Cultural/spiritual information:** These are separate required fields. If the client declines to answer or you were unable to assess, indicate this rather than writing N/A. N/A implies that culture and spirituality are not relevant.

- **Client strengths:** Skills, abilities, personality traits, and resources the client may possess, utilize, or have available that may benefit their mental health or treatment goals. This is usually written from the therapist's perspective.

- **Client's stated goals:** Outcomes the client desires from therapy, written in their own words when possible.
  "I want things to feel normal again. Or quit wanting to not wake up."
- **Diagnosis:** Write out the name of the condition with the ICD-10 code in parentheses. Diagnostic rationale must be included using DSM-5 criteria. Use verbatim DSM-5 language modifying for client specificity where possible.

Client meets criteria for major depressive disorder, recurrent, moderate (F33.1) due to client's report of the following: Depressed mood for most of the day nearly every day for a period of 3 months, markedly diminished pleasure in almost all activities, hypersomnia nearly every day (client reports sleeping up to 16 hours per day) ...

- **Recommendation and plan:** Describe services that would benefit the client based on their concern and anticipated benefits on well-being/functioning/symptoms. Include next steps for services or indicate if another path is to be taken (such as "Client would like to consider options and stated they will call if they decide to schedule a session,"). Give the date of a follow up session if possible.

  Client is recommended to attend individual therapy weekly to address mood symptoms impacting quality of life and to develop coping skills to assist with mood regulation. Client is recommended to continue medication management with the established prescriber. Client expressed eagerness to begin therapy and is scheduled for a follow up appointment on May 1, 2022. Clinician will coordinate care with prescriber as desired and authorized by client.

- **Brief mental status exam:** For explanations of many MSE terms, see the MSE Reference on the website.

Assessment Q&A

Are assessments always coded as 90791?

Almost always. Insurance plans have *benefit limits* and the assessment limit is one. It resets after a period of time, but circumstances can call for a second assessment before time is up. Here's how this can occur (although uncommon).

- ➔ Scenario 1: A client of 6 weeks was discharged due to scheduling difficulties. He contacts you to return to therapy and you see that his last session was 3 months ago. That's a long enough gap to justify re-assessment, however the initial assessment was only 4.5 months ago. **How can you proceed?** You hold a re-assessment and code as 90837.
- ➔ Scenario 2: Another Four Points therapist goes on leave and refers a client of 6 months to you while they're out. It's customary with transfers to conduct a new assessment, but this would mean two assessments 6 months apart within the same organization. **How can you proceed?** The client signs a consent for the primary therapist's assessment to be released and you review the assessment note. During the first session, you conduct a risk assessment and evaluate current symptoms with the client in lieu of holding a formal assessment.

What happens if something gets missed? What if I run out of time?

Ideally, all areas are covered, and we also know that many factors impact whether this can be achieved.

- ➔ Some factors involve the therapist: Reluctance to refocus the client, assessment skills that may be in the process of developing, or a general difficulty with structuring and managing time during sessions.
- ➔ And some factors involve the client: Arriving late for the appointment, presenting in crisis or appearing too dysregulated to proceed as usual, communicating with tangential speech and over-explanation such that attempts to create focus are not successful, or desiring for the appointment to serve another purpose than for assessment.

Missed content: You can revisit any missed questions during the next session. Document this in the follow-up session's progress note using language that specifies it's related to the previous appointment's intake assessment.

Remember that building rapport is an objective of the assessment, and hyperfocusing on a clipboard of questions can feel chilly and impersonal. Sometimes you miss an area for the sake of creating connection.

If you're short on time, refocus and tend to critical information:

- What you need for diagnosis: Symptoms, how the concern impacts daily life
- What you need for liability: What's the client's risk status? Do they endorse active suicidality/homicidality? If you miss an area, make it a different one. ☺
- What you need for ethical care: Is anyone else treating you for a mental health need?
- What you need for treatment plans: What are the client's goals regarding therapy?