

Communication Bulletin #5

To: Case Responsible Providers

From: Charles Schoenheit, Director of Access

Re: Direct provider access

October 28, 2004

We have worked out the details to enable providers to perform direct screening for non-emergency consumers who make initial contact with the provider rather than Access. Presently, consumers with routine types of problems are screened in the Access Unit, and providers do an immediate screening for consumers who contact them in emergency (and a few other) situations. **Beginning November 1, 2004, case responsible providers may choose to do their own initial screening for any consumer who contacts them directly, whether or not they have an emergency. Please note that providers are not required to do their own direct screenings. There is no reimbursement for screenings by providers. The Access Unit will continue to provide screenings as in the past.**

Here is how the process will work:

1. A consumer makes his/her initial contact with a case responsible provider in the Western Highlands Network.
2. The provider does a clinical screening and completes the Western Highlands Access - Screening Form. This form captures the necessary demographic and clinical information Access needs to authorize initial services.
3. There is also a place on the form where the provider must document that the consumer was offered a choice among the providers in the local area. The provider must indicate where, in the provider's records, details about the choices offered and the reason(s) for the choice are documented. Specific information about providers in the network is available at the Western Highlands website. Because consumer choice is an important tenet of Mental Health Reform, documentation about choice will be subject to review by the Community and Consumer Relations Department, and follow-up calls will be made to ask consumers about their experience.
4. The provider faxes the completed form to the Access Unit where the demographic and clinical information is reviewed and entered, target population membership is confirmed and initial services are authorized. Screenings should be faxed to the Access Unit (828-225-2782) as soon as possible and no later than the end of the next working day. Delayed submissions compromise our ability to effectively support your emergency response system. **Screenings that are incomplete or not legible will be returned to the provider with specific requests for additional information before services can be authorized.** Repeated submission of late or incomplete screenings will lead to termination of direct access for the provider.
5. Access then notifies the provider of the authorization.

It is essential that the Western Highlands Access - Screening Form be completed with no missing data. Follow-up requests to obtain missing information will waste time both for the provider and for Access.

If a provider does a full face-to-face clinical admission assessment (which is reimbursable) at the initial contact, those documents should be faxed to Access along with the Western Highlands Access - Screening Form, and the assessment will be retroactively authorized. Authorization of additional services will, of course, depend on whether the consumer meets eligibility requirements, etc.

In the event that the consumer chooses a different provider from one who does a direct screening, please contact Access and we will assist in making the necessary referral arrangements.

If you have easy questions or positive feedback, please feel free to contact me.

**Western Highlands Access - Screening Form**

**FAX # 828-225-2782**

Last Name	First Name	Middle Initial	Maiden Name
Client: _____			
Address: _____		City _____	Date of Contact: _____
Phone:(Home) _____ (Work or Cell) _____		State _____	Zip _____
Type of Contact: Telephone _____		Face-to-face _____	
Social Security # _____		Referral Source – Person, Agency, Address and Phone: _____	
Guardian _____		_____	
Age: _____ Birthdate: _____		Sex: M F _____	
Occupation or school and grade: _____		Employer: _____	
Marital Status: S M Sep D W _____		Ethnicity: _____	
Insurance: N Y _____		Type: _____	
Previous WHLME Contact: Yes No Case # _____		Primary Language Spoken: _____	

**Chief Complaint:**

**Presenting Problems** (circle):

As reported by: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Danger To Self:** None. Thoughts of suicide, Threats of suicide, Thoughts of death, Suicide attempt, Inability to care for self, Self harming behavior.  
When? \_\_\_\_\_ Plan? \_\_\_\_\_

**Past Danger to Self:** None. Thoughts of suicide, Suicidal gestures, Suicide attempts, Family history of suicide. Inability to care for self.  
When? \_\_\_\_\_ Method? \_\_\_\_\_

**Danger to Others:** None. Thoughts to harm others, Threats to harm others, Plans to harm others, Attempts to harm others, Has harmed others, Inability to care for others. When? \_\_\_\_\_ Plan? \_\_\_\_\_

**Past Danger to Others:** None. Thoughts to harm others, Threats to harm others, Plans to harm others, Attempts to harm others, Has harmed others, Inability to care for others. When? \_\_\_\_\_ Plan? \_\_\_\_\_

**Hospitalizations:** Mental Health: Total admissions \_\_\_\_\_ Hospitalizations in the last 2 years? \_\_\_\_\_

SA Facilities: Total admissions \_\_\_\_\_ SA admissions in the last 2 years? \_\_\_\_\_

Seasonal Patterns? No Yes describe \_\_\_\_\_

**Relationship Issues:** None. Conflict with peers, Siblings, Parents, Spouse, Significant other, Children. No/Few friends. Running away from home, Family desertion, Separation, Divorce, Visitation or custody disputes, Child neglect, Child abuse, Spouse abuse.  
(If Abuse, specify \_\_\_\_\_.) Death in family, No significant relationships. Other \_\_\_\_\_

**Medical Problems:** None. Disabled, Hearing impaired, Recent illness, HIV, HepC, Diabetes, Pregnant, Surgery, Other \_\_\_\_\_  
Physician \_\_\_\_\_ Pharmacy \_\_\_\_\_ Number \_\_\_\_\_

**Current Medications:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**Substance Use/Abuse:** Current Abuse: Alcohol N Y describe \_\_\_\_\_  
Amphetamines N Y describe \_\_\_\_\_  
Benzodiazepines N Y describe \_\_\_\_\_  
Narcotics N Y describe \_\_\_\_\_  
Cocaine/Crack N Y describe \_\_\_\_\_  
Marijuana N Y describe \_\_\_\_\_  
Hallucinogens/Inhalants describe \_\_\_\_\_

Name: \_\_\_\_\_

Has Abused: Narcotics, Amphetamines, Hallucinogens, Inhalants, Marijuana, Cocaine, Crack, Alcohol, Benzodiazepines, Pain killers.  
Other \_\_\_\_\_ Hospitalizations, Family problems, Job loss, Abuse related arrests. Other \_\_\_\_\_

Assess need for detoxification if client is currently impaired/intoxicated. Current pattern of use (what and how much): \_\_\_\_\_  
Date of Last Use \_\_\_\_\_

Alcohol Level? Date \_\_\_\_\_ Time \_\_\_\_\_ Method \_\_\_\_\_ Result \_\_\_\_\_

What withdrawal symptoms has she/he had in the past?  
DT's \_\_\_\_\_ Blackouts \_\_\_\_\_ Other \_\_\_\_\_

Current withdrawal symptoms: (circle those present) *If any symptoms exist, fill out the Medical Detoxification Screening Form*  
None. Vomiting Sweating Agitation Tactile disturbances Auditory disturbances Visual disturbances Headache Tremors/Shakes

**Depressive Symptoms:** None. Sadness, Fatigue, Increased/Decreased Sleep, Increased/Decreased Appetite, Hopelessness, Loss of interest, Feelings of worthlessness, Guilt, Agitation, Poor concentration, Crying, Anger, Social isolation, Irritability,  
Other \_\_\_\_\_

**Anxiety:** None. Anxiety, Conversion, Obsessions, Compulsions, Phobia, Multiple operations, Multiple somatic complaints, Nightmares, Panic Attacks, Separation anxiety, Soiling, Other \_\_\_\_\_

**Manic-Like Behavior:** None. Euphoria, Overtalkative, Sleep Loss, Grandiosity, Extravagance, Racing Thoughts, Other \_\_\_\_\_

**Developmental Disabilities:** None. TBI/ Head injury, Autism spectrum, Ambulatory, Verbal, Needs assistance with independent living skills, Needs assistance with ADL's, Borderline intelligence, Mental retardation/mild/moderate/severe.  
Other \_\_\_\_\_

**Psychotic/Organic Symptoms:** None. Unmanageable, Inability to care for self, Memory deficits, Withdrawn, Wanders off, Poor personal hygiene, Does not make sense, Suspiciousness, Sleep loss, Poor judgement, Forgetfulness, Confusion, Auditory hallucinations, Visual hallucinations, Delusions, Disorientation, Other \_\_\_\_\_

**Antisocial:** None. Frequent lying, Stealing, Excessive fighting, Destroys property, Fire setting, Arrests, Convictions, Imprisoned, Sexually inappropriate, Exhibitionism, Uses assumed names, Acts alone in peer group, Probation, Parole, Pending charges, Physically cruel to animals, Other \_\_\_\_\_

**Education Difficulties:** None. Behavior problems, Academic problems, Needs/receives special education, Needs technical training, Truancy, Drop out, Suspensions, Expulsion, Other \_\_\_\_\_

**ADD or ODD:** None. Hyperactivity, Impulse control, Attention span, Loses temper, Argumentative, Annoys others, Blames others,  
Other \_\_\_\_\_

**Other Information:** Homeless, Lives at shelter (which one?) \_\_\_\_\_ Lives with family/friends (Who?) \_\_\_\_\_  
Phone # \_\_\_\_\_ Would you like someone to contact you about affordable housing information? \_\_\_\_\_  
Financial Stress, Unemployed, Receives disability income, Cannot afford medications, Transportation problems.

**Summary/Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Urgency Designation:** Emergent (assess face to face within 2 hr.)      Urgent (assess face to face within 48 hr.)      Routine (assess face to face within 7 days)

**Consumer Choice:** Has this consumer been offered a choice of providers? Yes No  
Choices offered and reasons for choice are documented in: Admission assessment, Chart, Other \_\_\_\_\_

**Tentative Diagnosis:** \_\_\_\_\_

**Disposition:** Client to walk in and see \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_

Client seen and given an appointment to return for \_\_\_\_\_ at \_\_\_\_\_

Client referred to another provider: Provider Name \_\_\_\_\_

Appointment date and time \_\_\_\_\_

**Clinician signature and credentials:** \_\_\_\_\_

**Agency:** \_\_\_\_\_