# COMPREHENSIVE CARE MANAGEMENT

Policy Title:   Section 1:  **Health Home Comprehensive Assessment Policy (Adult and Children)**
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Approved by:                                                       Date:

**Purpose:**  To establish standards and guidance regarding the Health Home comprehensive assessment which will inform NYS Health Home and Care Management Agencies' policies and procedures.

The New York State Department of Health (the Department) is responsible for the oversight of Health Homes (HH), a care management service model which ensures all the professionals involved in a member's care communicate with one another so that the member's medical, behavioral health (mental health and/or substance use disorders) and social service needs are addressed in a comprehensive manner.  The HHs contract with a network of Care Management Agencies (CMAs) who provide person centered, recovery oriented, data driven care coordination, as well as Managed Care Plans (MCP) to provide HH care coordination for plan members. Care management will reduce unnecessary emergency department visits and inpatient stays and improve medical and behavioral health outcomes.

**Policy**

As specified in the NYS State Plan Amendment 14-0016, Health Homes are required to provide *Comprehensive Care Management*, as part of the six Health Home Core Services.  Within *Comprehensive Care Management*, a comprehensive health assessment that identifies medical, behavioral health (mental health and substance use) and social services is required.

The Department will ensure that Health Homes establish and maintain policies and procedures that define how and when the comprehensive assessment is completed for all consented HH members; the frequency at which the comprehensive assessment will be conducted; clear and focused training on how the comprehensive assessment is administered; how various elements will be obtained; and a quality assurance program to ensure compliance with specified requirements.

Unless specifically stated, this policy applies for adults and children.

**The Health Home Comprehensive Assessment for all Health Home Members**

A comprehensive assessment is both a mandatory functional approach for data collection, as well as an ongoing, dynamic process of information gathering, and an

evaluation of a member's health care and related needs. The information collected must result in a fully integrated plan of care.  The comprehensive assessment will include:

- *verification* that an assessment of eligibility and appropriateness for Health Home services has been conducted;
- a screening tool that evaluates high risk behavior that may jeopardize the individual's overall health and wellbeing;
- a detailed description of the member's medical and behavioral health (mental health and substance use), as well as psychosocial conditions and needs;
- an assessment of social determinants of health including a member's lifestyle behaviors, social environment, health literacy, communication skills and care coordination needs such as entitlement and benefit eligibility and recertification;
- self-management skills and functional ability (thinking and planning, sociability/coping skills, activity/interests); and
- the member's strengths, support system, and resources
- if applicable, for adolescents and transition age youth, independent living skills/coping skills and transition to adult services;
- if applicable, for children and toddler's child development milestones and growth chart.

The Health Home comprehensive assessment will identify service needs currently being addressed; service and resource needs requiring referral; gaps in care and barriers to service access; and the member's strengths, goals, and resources available to enhance care coordination efforts and empower individual choice and decision making. The care manager will assess for risk factors that will include but not limited to HIV/AIDS; harm to self or others; persistent use of substances impacting wellness; food and/or housing instabilities.  The department has suggested standardized best practice screening tools across multiple domains to support care mangers in their role of early identification, referral and linkage to clinical interventions for high risk individuals. This process is not intended to be a clinical intervention, but rather an early identification of need as part of the care management process. Health Homes must provide training, guidance, and resource support for CMAs to support early identification of risk factors.

With member consent, information should be gathered from a variety of sources, for example, current service providers; family and natural supports; community based resources such as housing case managers; faith based organizations identified by the individual; and member self-report. Where information can be obtained, and transferred from other Health Home assessments or evaluations, this information can be used to populate the comprehensive assessment.  For example, the required elements of the comprehensive assessment may be collected within different documentation gathered and stored in the electronic health record.  The Health Home will provide direction to support CMAs in understanding the link of each document and how it fulfills the comprehensive assessment requirements.

A Health Home supports continuity of care and health promotion through the development of a supportive relationship with the individual and their care team. Care

team members can assist the care manager in providing historical information, current service/program care plans, and reviewing outcomes of the assessment information. However, the Health Home care manager takes full responsibility for the assessment process and required documentation as the single point of contact for the coordination of care as outlined in this policy.

**If an adult** served by a Health Home is enrolled in a HARP Medicaid Managed Care Plan or is a HARP-eligible member enrolled in a HIV/Special Needs Plan, the Health Home care manager must educate the member about Behavioral Health Home and Community Based Services (BH HCBS) and eligibility determination.  If the member consents to an eligibility assessment, a Health Home care manager trained on the NYS Eligibility Assessment or a qualified State designated entity must administer the adult NYS Eligibility Assessment for BH HCBS. Please review the guidance, *Managed Care Organizations, Adult Health Homes, Care Management Agencies, and Providers for the administration of the NYS Eligibility Assessment for BH HCBS and the NYS Community Mental Health Assessment*: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/harp_hiv_snp.htm

**Frequency**

The initial comprehensive assessment must be completed concurrently with an initial plan of care within 60 days of enrollment.  An assessment may be completed over the course of several days; at least one of these encounters during the initial assessment period will be face to face.  Health Home policy must clearly identify required timeframes for completion of the initial assessment and plan of care and implement quality review of these timeframes to ensure adherence.

An annual reassessment of each member is required. If the member experiences a significant change in medical and/or behavioral health or social needs before the annual review, a comprehensive assessment is not necessary. However, the care manager should perform an abbreviated evaluation of the member's current status including rescreening for risk factors; it should then be reviewed and signed by a supervisor.  For children, the care manager should also perform a CANS-NY Reassessment if the significant event meets one of the seven "Reasons for an Early CANS-NY Reassessment" (see glossary).  Any changes in the member's goals or service needs should be reflected in the POC and trigger a case review with a supervisor or applicable members of the care team. Such significant changes to the member's condition and/or POC should be reflected later in the annual reassessment.

**Training**

Health Homes should have clear and focused operationalized policies and procedures that provide well-defined direction to care managers and CMAs regarding training for, and administering of, the comprehensive assessment tool. Health Homes must provide access to and information regarding training opportunities that include understanding the purpose and function of the comprehensive assessment, recovery oriented, person-

centered care planning, as well as evidence-based methods for increasing engagement such as motivational interviewing.

**Quality Management Program**

Health Homes must have a quality assurance process in place to ensure that care managers and care management providers comply with HH policies and procedures (Please see Quality Management Program Policy).  Quality indicators may include:

- Comprehensive assessment is administered within required timeframes
- Documentation/verification has been obtained using various sources, including primary care provider (PCP), behavioral health and substance abuse provider, PSYKES, a RHIO, or MCO within 30 days
- Comprehensive assessment is administered annually
- All required components are addressed
- Member's care team included during assessment process
- Supervisor was engaged for high risk members/evidence of adverse event
- CANS-NY was utilized to assist with the comprehensive assessment and POC (children)

**Health Homes Serving Children and the Child and Adolescent Needs and Strengths-New York (CANS-NY)**

As part of the Health Homes Serving Children program, the Child and Adolescent Needs and Strengths-New York (CANS-NY) must be completed for enrolled Health Home members to determine Health Homes Serving Children acuity, as well as to guide service planning specifically for children and adolescents under the age of 21 with behavioral needs, medical needs, developmental disabilities and juvenile justice involvement.  The CANS-NY does not replace the required health home comprehensive assessment.

While the CANS-NY can assist a Care Manager in identifying areas of needs and strengths, details of those needs and strengths are not included within the CANS-NY ratings.  For example, the CANS-NY does not include information such as a member's medical diagnosis, name of their treatment providers or compliance with treatment.  Additionally, there are other areas that are important for the Health Home care manager to be aware of that are not highlighted or specific within the CANS-NY such as medications, types of treatments and HIV/AIDS measures.  The CANS-NY can be used by the care manager to assess what are important areas to the child and family to focus on in the comprehensive assessment and in the plan of care.

Completion of the required comprehensive assessment for children ensures that care managers are obtaining additional details regarding a member's situation.  Information as part of the comprehensive assessment assists the Care Manager in having an overall awareness of the child and family.  If there is a need for additional services, the Care Manager provides linkage to those services.

The best practice for completion of the CANS-NY is 30 days from the date of Health Home enrollment.  Children's Health Homes have up to 60 days for completion of the initial comprehensive assessment and plan of care.  An annual Comprehensive Reassessment is required.  When reviewing and updating the CANS-NY, the Care Manager must also review and update the member's comprehensive assessment and plan of care.  The CANS-NY must be completed every 6 months from the date of last completion.

Required components of the Health Homes Serving Children Comprehensive Assessment are included in Appendix C.

Appendix A

# Glossary of Terminology

- **Adverse (Significant) event**

  An event involving a member, which has, or may have, an adverse effect on the life, health, or welfare of the member and/or another person. This can include:
  - ❖ a change in functioning (including an increase or decrease of symptoms or a new diagnosis);
  - ❖ in-patient or outpatient hospital admittance and/or discharge;
  - ❖ a serious injury; or
  - ❖ admittance, discharge or transfer from detox or residential placement; or
  - ❖ a significant change in housing or support resources.

- **BH HCBS** (Behavioral Health Home and Community Based Services)

  Behavioral Health Home and Community Based Services (BH HCBS) provide opportunities for adult Medicaid beneficiaries with mental illness and/or substance use disorders to receive services in their own home or community. This model of care emphasizes and supports a person's potential for recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, educational, employment, housing, and health and well-being goals. Implementation of BH HCBS will help to create an environment where managed care plans, service providers, plan members, families, and government partner to help members prevent and manage chronic health conditions and recover from serious mental illness and substance use disorders.

- **Care manager**

  Care managers direct a set of activities designed to assist members and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aim of improving the member's health status and reducing the need for medical services. The goals of care management are to improve the member's functional health status, enhance coordination of care, eliminate duplication of services, and reduce the need for expensive medical services. *(Robert Wood Johnson Foundation)* The health home provider will assign each individual a dedicated care manager who is responsible for overall management of the member's care plan. The health home care manager should be clearly identified in the member's record.

- **Child and Adolescent Needs and Strengths-New York (CANS-NY)**

  The Child and Adolescent Needs and Strengths-New York (CANS–NY) serves as a guide in decision making for Health Homes Serving Children regarding acuity, as well as to guide service planning specifically for children and adolescents under the

age of 21 with behavioral needs, medical needs, developmental disabilities and juvenile justice involvement.

- **Care team (also called interdisciplinary or multidisciplinary team)**

  Providers and support services focused on promoting and optimizing the health and welfare of the HH member; each member of the care team has specific responsibilities and the whole team contributes to the care of the HH member.  Care Team members may include:

  - ❖ Clinical providers (e.g. primary care, specialty care, home health care, etc.)
  - ❖ Service providers (e.g. peer supports, support groups/self-care programs or agencies, transportation, etc.)
  - ❖ The MCO care manager
  - ❖ Other key supports:  hospital discharge planners, disease management care managers, PCMH care managers, peer supports, caregivers, family members, etc.

  All members of the team will be responsible for reporting back to the care manager on patient status, treatment options, actions taken and outcomes as a result of those interventions. All members of the team will also be responsible for ensuring that care is person-centered, culturally competent and linguistically capable.

- **Consent** (DOH 5055 and DOH 5201 for children)

  The Health Home consent form allows the Health Home to share the member's protected health information (PHI) on the member with other downstream partners agreed upon by the member and identified on the consent form. When PHI is properly shared, services can be coordinated based on a reasonable understanding of the member's health care needs and medical history.

- **HARP** (Health and Recovery Plan)

  A Health and Recovery Plan (HARP) is a distinctly qualified, specialized managed care product that manages physical health, mental health, and substance use services in an integrated way for adults 21 and over who are eligible for Medicaid Managed Care and meet serious mental illness (SMI) and substance use disorder (SUD) targeting criteria and risk factors. HARPs also manage the enhanced benefit package of Adult Behavioral Health Home and Community-Based Services (Adult BH HCBS).

- **Medicaid Managed Care Organization** (MMCO)

  A MMCO is a managed care entity that is certified by, and contracted with, the State to deliver Medicaid health benefits and additional services through a Medicaid Managed Care system.  Managed Care is a health care delivery system organized

to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid Managed Care.

- **Reasons for an Early CANS-NY Reassessment (children)**

  For children, a CANS-NY must be completed every 6 months from the date of the last completion, unless the following occurs requiring the CANS-NY to be completed sooner than 6 months:

  1. Significant change in child's functioning (includes increase or decrease of symptoms or new diagnosis)
  2. Service plan or treatment goals were achieved
  3. Child admitted, discharged or transferred from hospital/detox, residential placement, or foster care
  4. Child has been seriously injured or in a serious accident
  5. Child's (primary or identified) caregiver is different than on the previous CANS
  6. Significant change in caregiver's capacity/situation
  7. Court request

- **Risk Screening**

  Identification of a member's potential for harm to self or others. Identification of potential risk will inform the need for possible additional assessment (by a licensed practitioner), development of a safety plan, and/or additional service coordination by the care manager. Being aware of a member's prior history of high-risk behaviors and development of a safety plan will help prepare a care manager in the event the member's status may require crisis intervention at any time.

  Areas of high-risk include: ideation or attempts of self-injury, suicide and homicide; violence; and arson. Legal interventions such as parole/probation status, restraining orders, and/or AOT may help further define level of risk and help inform care coordination activities.

  Other risk areas may include risk of HIV exposure, asthma exacerbation, complications from diabetes, risky substance use, hospitalization, ED use, homelessness, etc.

  Motivational interviewing, documentation from other providers (with the member's consent) and/or consult with a supervisor may be utilized to obtain a complete risk history, in the event the member does not fully disclose information. There are a number of evidence-based screening tools available that Health Homes may wish to incorporate into their assessment process.

- **Social Determinants of Health**

  Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health,

functioning, and quality-of-life outcomes and risks. Examples of social determinants include:

Economic Stability
    Poverty
    Employment
    Food Security
    Housing Stability
Education
    High School Graduation
    Enrollment in Higher Education
    Language and Literacy
    Early Childhood Education and Development
Social and Community Context
    Social Cohesion
    Civic Participation
    Discrimination
    Incarceration
Health and Health Care
    Access to Health Care
    Access to Primary Care
    Health Literacy
Neighborhood and Built Environment
    Access to Healthy Foods
    Quality of Housing
    Crime and Violence
    Environmental Conditions

Source: *"Healthy People 2020 Social Determinants of Health" HealthyPeople.gov. U.S. Department of Health and Human Services, 27 Jul. 2015.*

Appendix B

# Required Components of the Health Home
# Comprehensive Assessment (Adult)

*The Health Home consent form (DOH 5055) must be completed and include all providers referenced through the comprehensive assessment, as well as the MMCP and Behavioral Health Organization (BHO) as applicable.*

*A response is required for every query on the HH's comprehensive assessment. An answer of "N/A" is not an acceptable response. Examples of acceptable responses include "member has no known prior history of ___," "member and family deny history of ___," "member refused to answer question at the time of assessment," or "prior medical records/previous assessment doesn't indicate ___."*

*Documentation/verification for these components should be obtained from various sources, including a primary care provider (PCP), PSYKES, a RHIO, or MCO.*

The components of the comprehensive assessment must include the following:


**Identification Information**

**Health Home eligibility and appropriateness criteria (can be completed during intake and verification noted in assessment)**
Medicaid eligible & active
At least two chronic conditions OR
Single qualifying condition
- HIV
- SMI

Appropriateness for HH services
- Significant behavioral, medical, or social risk factors
- Consented (DOH 5055)

**HIV/AIDS**
*Key relevant screening questions, motivational interviewing*

Current HIV status
CD4 Count:          Date:
Viral Load:          Date:


Verification method of CD4 and VL
Does client understand meaning of VL and T-cell Count and how to read lab
  results (Explain)

Does client need referral for further HIV information/education?  Yes/No
Does the person need referral for HIV testing?  Yes/No   Last time tested?
Does client have history of STI's, injecting substances, unprotected sex?
Is there engagement in treatment plan/services?
Identify barriers to service and treatment

## Mental Health Services
*Key relevant screening questions, motivational interviewing*

Psychiatric history
- Illness history (historical timeline from age of onset of mental illness)
- Hospitalizations and other treatments

Member's current problems
- Service use within the last 12 months
- Current functioning
- Symptoms and severity
- Diagnoses
- Dangerous behavior/suicidality
- Trauma/abuse history
- domestic violence (APS/CPS)

Strengths of member
Is there engagement in treatment plan/services?
Identify barriers to service

## Substance Use Disorder
*Key relevant screening questions, motivational interviewing*

- Systematic screening method for identifying risky use or potential SUD using an OASAS approved tool (i.e. AUDIT and DAST);
- History of substance use and dependence (substance, route of administration, frequency, duration);
- Treatment history, including current treatment (facility/provider, dates, duration, discharge status);
- Current/recent use of alcohol and drugs (list substances, route of administration, amounts and frequency);
- Social context of substance use;
- How substance use/dependence affects daily living: (why the person takes substances, behavior problems, daily living skills, employment, relationships, finances, psychiatric symptoms, self-medication);
- Does member understand consequences of substance use?
- Motivation to change;
- Specific behavioral information on substance use & mental health disorders & how they influence each other, if applicable;

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- Current Recovery Support (peers, recovery center, self/mutual help groups)

Referral to treatment needed?
Strengths of member
Identify barriers to service

## Medical Health Care
*Key relevant screening questions, motivational interviewing*

Current medical diagnoses; for each diagnosis (illness), assess:
- Illness history
- Hospitalizations and other treatments
- Symptoms and severity
- Adherence to treatment
- Is illness controlled or uncontrolled

Health promotion *(examples)*
- BMI
- Diabetes/metabolic disease
- Asthma/respiratory disease
- Cardiovascular disease
- Living with HIV/AIDS

Consented (DOH 5055)
Is there engagement in treatment plan/services?
Identify barriers to service

## Independent Living Skills
*Key relevant screening questions, motivational interviewing*

Functional assessment, performance & capacity
- meal prep/needs assistance eating
- housekeeping/cleanliness
- managing finances, ability to shop
- managing medications
- phone use/communication modes
- transportation
- ability to dress, bath self; personal hygiene; toileting
- mobility, positioning, transferring
- tie back to medical/behavioral health components
- memory/learning

Needs interpretation services
Interest in self-help, advocacy, and empowerment activities
Social support network
Family support systems
Does member have support to help with instrumental activities of daily living
Strengths of member
Identify barriers to service

**Social service needs**

*\*Key relevant screening questions, motivational interviewing*

Housing
- risk of eviction questions (required by Gov. office)
- what type of housing does the person have now? how long there?
- how many times has the person moved in last 6-12 months?

Social Security
Supplemental Nutrition Assistance Program (SNAP)
Clothing
Financial resources/representative payee
Any additional social service needs
Advanced directives
Legal needs/status (incarceration, probation, etc.)
Strengths of member
Identify barriers to service

**Vocational/educational status**

*\*Key relevant screening questions, motivational interviewing*

Level of education
History of employment
Access to vocational rehabilitation and employment programs
- Ticket to work
- Welfare to work

Skills and resources needed to achieve goals/identify strengths
Strengths of member
Identify barriers to service

**Medications**

*\*Key relevant screening questions, motivational interviewing*

Pharmacy that member uses
Contact information of previous prescribers
Current medication treatments and doses
- Medical health meds
- Behavioral health
- Medication Assisted Treatment for SUD
- Pain management
- HIV/Aids medication

Member's understanding of medication and use
Indication as to why member with chronic condition has no medication
Medication adherence
Identify barriers to taking medications
Identify supports that would assist with med management

**Providers**

*Key relevant screening questions, motivational interviewing*

HIV medical provider(s)
Mental health provider(s)
Medical health provider(s)/specialists
Substance use disorder treatment providers
Other community based providers and/or faith based supports
Peer support provider

Appendix C

## Required Components of the Health Home Comprehensive Assessment (Children)

*All providers identified on the comprehensive assessment as well as the Medicaid Managed Care Organization (MMCO), should be listed on the Health Home consent form (DOH 5055 or 5201).*

*Documentation/verification for these components could be obtained from various sources, including a primary care providers (PCP), CANS-NY, PSYKES, a RHIO, or MCO. Providers are encouraged to utilize regional health information organizations (RHIOs) or Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), each a qualified entity to access patient data to and maximize the use of Health Information Technology (HIT) across providers.*

*Please Note: The CANS-NY does not provide detailed and specific information to fully complete the comprehensive assessment to populate the plan of care and to provide comprehensive care management services. However, the CANS-NY can inform areas of specific needs where attention should be paid within the comprehensive assessment.*

*If the CANS-NY has already been completed, there may be areas within the CANS-NY with a rating of a 1, that require the care manager to explore further to determine if that area should be a part of the plan of care as a preventive action.*

*For example:* On the CANS-NY 6-21, see Question 46

*Dental Needs: This item refers to the child's need for dental health services*
*0 No evidence of any dental health needs or needs are currently being addressed appropriately.*
*__1 Child has not received dental health care and requires a checkup. Child may have some dental health needs but they are not clearly known at this time.__*
*2 Child has dental health needs that require attention.*
*3 Child has serious dental health needs that require intensive or extended treatment/intervention.*

*A child that has never been to the dentist may be rated as a 1 at the time of their CANS-NY assessment, however, in the future as a result of not receiving dental health care, could later acquire dental health needs that require further attention. A health home care manager can focus on areas with a low rating on the CANS-NY as part of their work with the child and family on the comprehensive assessment and the plan of care.*

*A response is required for every query on the HH's comprehensive assessment. An answer of "N/A" is not an acceptable response. Examples of acceptable responses include "member has no known prior history of ___," "member and family deny history of ___," "member refused to answer question at the time of assessment," "prior medical*

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*records/previous assessment doesn't indicate \_\_\_," or, in the case of children or youth, "not age appropriate."*

**Identification Information**

**Member Information**
*\*(If the demographic information in the CANS-NY has already been populated, it can be printed and placed in the member's record unless it is required as part of the Health Home HIT platform for the comprehensive assessment)*

- The child/adolescent's emergency contact information.
- Parent/guardian/legally authorized representative information.
- Medical consenter for children in foster care if different from above.

Acculturation/Language
- Ethnic/Cultural Background
- Primary language of the child/adolescent and family
- Secondary language of the child/adolescent and family
- Is a translator, interpretative services or native language speaker needed or involved?
- Spirituality/Faith
- Gender Identity
- Sexual Orientation
- Gender Expression

Support System
- General health and wellbeing of caregiver
- Other relationships and social supports

Emergency Planning
- Fire, health, and safety issues.
- Natural disaster and other public emergency

**Health Home Eligibility and Appropriateness Criteria**
**(can be completed during intake and verification noted in assessment)**
- Medicaid eligible & active
- At least two chronic conditions OR
- Single qualifying condition
  HIV/AIDS
  Serious Emotional Disturbance (SED)
  Complex Trauma

Appropriateness for Health Home Services

- At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- Has inadequate social/family/housing support, or serious disruptions in family relationships;
- Has inadequate connectivity with healthcare system;
- Does not adhere to treatments or has difficulty managing medications;
- Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- Has deficits in activities of daily living, learning or cognition issues, or
- Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

**HIV/AIDS**
*Key relevant screening questions, motivational interviewing (HHSC Care Managers are required to complete Motivational Interviewing training as part of HHSC Care Manager training requirements)*

Current HIV status
    CD4 Count:          Date:
    Viral Load:          Date:
    Verification method of CD4 and VL.
    Does client/family understand meaning of VL and T-cell Count and how to read lab results? (Explain)
    Does child/adolescent need referral for further HIV information/education? Yes/No
    Does the child/adolescent need referral for HIV testing?  Yes/No Last Time tested?
    Does child/adolescent have history of STI's, injecting substances, unprotected sex?
    Is there engagement in treatment plan/services?
    Was the child exposed to HIV perinatally or after birth?
    PrEP or Pep?

**Mental and Behavioral Health Services**
*Key relevant screening questions, motivational interviewing*

Psychiatric history
Psychiatric Illness history (historical timeline from age of onset of mental illness)

Psychiatric Hospitalizations and other mental health treatments

Current psychiatric status of member
    o Service use within the last 12 months
    o Current functioning
    o Symptoms and severity

- o Diagnoses
- o Dangerous behavior/suicidality
- o Frequency of mental health treatment

Is there engagement in treatment plan/services?
Strengths of member
Barriers to service

**Substance Use Disorder**
*Key relevant screening questions, motivational interviewing*

- Systematic screening method for identifying risky use or potential SUD using an OASAS approved tool (i.e. AUDIT and DAST);
- History of substance use and dependence (substance, route of administration, frequency, duration);
- Treatment history, including current treatment (facility/provider, dates, duration, discharge status);
- Current/recent use of alcohol and drugs (list substances, route of administration, amounts and frequency);
- Social context of substance use;
- How substance use/dependence affects daily living: (why the person takes substances, behavior problems, daily living skills, employment, relationships, finances, psychiatric symptoms, self-medication);
- Does member understand consequences of substance use?
- Motivation to change;
- Specific behavioral information on substance use & mental health disorders & how they influence each other, if applicable;
- Current Recovery Support (peers, recovery center, self/mutual help groups, Youth Clubhouse)

Referral to treatment needed?
Strengths of member
Identify barriers to service

**Medical Health Care**
*Key relevant screening questions, motivational interviewing*

Current medical diagnosis(es); for each (illness)
- Illness history
- Hospitalizations and/or other treatments (intensity of treatment)
- Symptoms and severity (i.e., life threatening, chronic, complex)
- Adherence to treatment
- Is illness controlled or uncontrolled?

Health Promotion (examples)
- o BMI

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- o Diabetes/metabolic disease
- o Asthma/respiratory disease
- o Living with HIV/AIDS
- o Adequate/ Inadequate physical activity?

Strengths of member
Is there engagement in treatment plan/services?
Identify barriers to service

Current Dental Care
- o Member's last dental checkup?
- o Does member have current dental care needs and if so, what are the member's dental care needs

Instrumental Activities of Daily Living
- o What are child/adolescent's current strengths and needs with IADLs?
- o Does the child/adolescent have supports in place? What are those supports?

Self-Care Activities of Daily Living
- o What are child/adolescents current ADL strengths and needs
- o Does the child/adolescents have supports in place? What are those supports?
- o Does the child require use of adaptive equipment/technology?

Allergies

**Medications**
*Key relevant screening questions, motivational interviewing*

Pharmacy that member uses
Contact information of previous prescribers.
Current medication treatments and doses.
- o Medical health medications
- o Behavioral health medications
- o Medication Assisted Treatment for SUD?
- o Pain management?
- o HIV/AIDS treatment? PrEP and PeP?

Member/Family's understanding of medication and use
Indication as to why member with a chronic condition has no medication
Medication adherence
Identify barriers to taking medications (i.e.: is member/family able to afford medication)
Identify supports that would assist with medication management.

**Providers**
*Key relevant screening questions, motivational interviewing*

Treatment Providers Identified

HIV and/or AIDS Institute Providers and Supports
Mental health provider(s)
Medical health provider(s) and specialists
Medical Supplies/Equipment Vendor
Substance use disorder treatment providers

Other community based providers and/or faith based supports
Peer support provider(s)

**HHSC Consent Forms Needed for Treatment Service Providers**

- *Health Home Patient Information Sharing Consent DOH (Form 5055)* **Or**
- *Health Home Consent Information Sharing DOH (Form 5201)*

Child and Adolescent Needs and Strength-New York (CANS-NY)
- *Functional Assessment Consent DOH (Form 5230)* needed for assessment.
- Appropriate clinical documentation to support CANS-NY

**Development Milestones**
*Key relevant screening questions, motivational interviewing*
- Growth Chart
- Details of developmental delay
- Frequency of treatment
- Dates of last assessments
- Any current referrals to services
- Does child require further supports
- Input from child/adolescent and family regarding child development
- Details of any risks associated with developmental conditions

**Complex Trauma**
*Key relevant screening questions, motivational interviewing*

Trauma/Abuse History

- o Are Complex Trauma screen, assessments, and/or determination needed?
- o What are child's trauma symptoms?
- o Has child/adolescent had a Complex Trauma determination?  If so, name of Licensed Professional who has completed assessments and is that Licensed Professional currently the treating provider?

**Risk Behaviors and Factors**
*Key relevant screening questions, motivational interviewing*

Self-Harm
- Self-harm behaviors (i.e., cutting, head banging, hair pulling)

- Fire Setting (history or recent; intentional or accidental)
- Problematic social behaviors

Suicide Risk
- Current suicidal ideation or recent suicidal ideation?
- Recent suicidal gestures?
- Have self-injurious behaviors resulted in crisis/ER assessment or mental health hospitalization?

Danger to Others
- Recent or history of aggressive/assaultive behaviors
- Any recent or history of homicidal ideation/threats
- Have homicidal ideation/aggressive/assaultive behaviors resulted in crisis/ER assessment, mental health hospitalization or legal intervention?

Sexual Behavior
- Sexually aggressive behaviors
- Pregnancies
- STIs
- Unprotected Sex

Runaway
- Any recent runaway behaviors and means to run away?
- When runaway behaviors occurred and for how long
- Were authorities contacted (i.e.:  police, Statewide Central Register of Child Abuse and Neglect)
- Identified reasons for runaway behaviors

Eating Disorders
- Any eating disorder diagnosis (i.e., anorexia, bulimia, obesity)?
- Any eating disorder symptoms (i.e., PICA, binge eating, hoarding food)?
- Treatment providers for eating disorders

Juvenile Justice/Legal
- Current legal situation and charges
- History of delinquent behavior
- Guardian Ad Litem/Lawyer Information
- Juvenile/Adult Court Information
- Juvenile Placement/Detention/Incarceration history

Indicators of Child Abuse and Maltreatment (Including Neglect) – *Care Managers are required to complete Mandated Reporting training as part of HHSC Care Manager training requirements*
- Behaviors by caregivers in the home that pose a risk to the child
- Indicators of physical abuse

- Indicators of sexual abuse
- Indicators of maltreatment

Bullying
- Nature and details of bullying
- History of victim or perpetrator of bullying
- Any current supports to address bullying (i.e. therapy, groups, etc.)

**School/Academic Function**
*Key relevant screening questions, motivational interviewing*
- Does the child have an IEP, special education, or general education?
- If learning disability, what are current services and accommodations in the school system?
- Service plan and durations
- Frequency of services
- Are medical accommodations needed?
- Grade level, school, teachers, educational attainment.
- Details of child's behavior when attending school
- Additional details from preschool/child care, educational partnership, achievement, attendance, relationship with teachers/peers, learning ability.
- Name of school/preschool/early intervention center or provider.
- Teachers and other school providers (i.e.: school counselor, social worker, psychologist)
- Skills and resources needed to achieve goals/identify strengths
- Strengths of member
- Identify barriers to service

**Independent Living Skills**
*Key relevant screening questions, motivational interviewing*

Employment
History of employment
Level of workforce development training and education?
Access to vocational rehabilitation and employment programs?
- Ticket to work?
- Welfare to work?
Skills and resources needed to achieve goals/identify strengths
Strengths of member
Identify barriers to service

**Social service needs**
*Key relevant screening questions, motivational interviewing*

Housing
Risk of eviction questions (required by Gov. office).
What type of housing does the person have now? How long there?

How many times has the person moved in last 6-12 months?
Quality of housing, environmental conditions
Crime and Violence
Legal Status Impact on Housing (i.e. Incarceration, probation, etc.)

Financial
- Supplemental Security Income (SSI) Benefits?  Y/N
- Other Financial Resources (i.e.: Employment)
- Financial resources/representative payee?
- Other insurance (y/n) and name
- Other public social service benefits

Food Security
- Member and family access to and availability of healthy foods
- Quality of diet
- Supplemental Nutrition Assistance Program (SNAP) benefits? WIC (Women, Infants, Children) Program benefits?
- Availability of healthy food resources in the community (i.e.: Just Say Yes, SNAP, local food pantry)
- Link to NYS DOH Nutrition Programs and Nutrition Related Information: http://www.health.ny.gov/prevention/nutrition/

Transportation

- Access to public or private transportation?  If so, what is the mode of transportation?
- Medical transportation required or needed (i.e., wheelchair, stretcher)?

Skills and resources needed to achieve goals/identify strengths
Strengths of member
Identify barriers to service