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

Implementation Date: The portions of this policy that provides relief from duplicative collection of information on separate children's Comprehensive Assessments and CANS/UAS Assessments effective retroactive to March, 5, 2025. Health Homes are required to fully implement all updates to the policy across their networks by August 22, 2025.

Applicable to: Health Homes Serving Adults, Health Homes Serving Children (HHSC), and Health Home Care Management Agencies (CMA)

Note for Health Home Serving Children: Effective March 4, 2025, a number of Comprehensive Assessment components were consolidated within the Uniform Assessment System (UAS-NY) which houses the **Child and Adolescent Needs and Strengths (CANS-NY)** assessment. From March 5, 2025, onward, the due date for the next Comprehensive Assessment for each HHSC member is to align with the due date of the next CANS-NY. It will not be necessary for the Care Manager and member to complete both a stand-alone Comprehensive Assessment document and UAS/CANS-NY, as long as the comprehensive assessment items (appendix A) missing from the UAS/CANS-NY are captured somewhere in the Health Home EHR. For more information, refer *to section III. Timelines for Completing Comprehensive Assessments – Initial Comprehensive Assessment – For Health Homes Serving Children.*

Purpose: To establish standards and guidance regarding the Health Home Comprehensive Assessment which will inform the development of the Plan of Care, the delivery of care coordination, and the Health Homes 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 Health Homes contract with a network of Care Management Agencies (CMAs) which provide person centered, recovery oriented, data driven care coordination, as well as Managed Care Plans (MCP) to provide Health Home care coordination for plan members. Care management will reduce unnecessary emergency department visits and inpatient stays and improve medical and behavioral health outcomes.

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Definitions

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

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.

- **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 twenty-one (21) with behavioral needs, medical needs, developmental disabilities and juvenile justice involvement. The assessment also serves as the tool used to collect much of the information needed for the Comprehensive Assessment of members enrolled in Health Homes Serving Children.

- **In-Person**

An interaction that must be conducted with both the member and Health Home care manager physically in the same location. This type of interaction cannot be done via telehealth.

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

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. Health and Recovery Plans (HARPs) also manage the enhanced benefit package of 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.

- **Member or Participant**

The individual (both adult and children/youth) enrolled in the Health Home program. The term includes the Parent, Guardian, and Legally Authorized of the member, as applicable. These terms are interchangeable.

- **Multidisciplinary Team (MDT)/Interdisciplinary Team (IDT)/Child & Family Team Meeting (CFTM)/Case Review Meeting/Case Conference/Care Conference/Care Team Meeting members**

Consists of the Health Home care manager, member, member supports (including parent, guardian, legally authorized representative), Medicaid Managed Care Plan (MMCP), healthcare, and service providers, collaterals and others approved by the member to ensure member needs are addressed in a comprehensive manner. The composition of a Multidisciplinary Team may vary at any point in time during the member's enrollment and from member to member. <u>These terms can be used interchangeably.</u>

- **Risk Screening**

Identification of a member's potential for harm to self or others, or risk of safety and well-being of the member by others, especially in regard to children and youth. Identification of potential risk will inform the need for possible additional assessment (by a licensed practitioner or specific practicing provider i.e., child welfare), 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 or family situation 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. Other high-risk for children/youth may be abuse, neglect, exploitation, lack of obtaining treatment, medication, services, etc. Legal interventions such as parole/probation/law enforcement status, restraining orders, child welfare, and/or Assisted Outpatient Treatment (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, Emergency Department use, homelessness, etc.

- **Significant Life 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, but is not limited to:

  - Significant change in member's functioning or condition (including increase or decrease of symptoms or new diagnosis)
  - Member admitted, discharged or transferred from hospital/detox, residential placement, arrest/detention/incarceration, or foster care
  - Member's been seriously injured or has medical/behavioral health event a major
  - Change in the member's caregiver (for children/youth, primary or other identified) guardian, legally authorized representative
  - Significant change in caregiver's capacity/situation
  - Court request or order e.g., Assisted Outpatient Treatment (AOT)
  - Significant change in housing or support resources

- **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

Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 03/20/2025 from https://odphp.health.gov/healthypeople/objectives-and-data/social-determinants-health

- **Telehealth**

The use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member. Telehealth is utilized based upon the request of the member/caregiver and must be documented within the case record. Care managers must also adhere to general Medicaid telehealth guidance when delivering services via telehealth, which requires that services be based on the best interests and needs of the member, not those of the provider nor for the convenience of the provider.

- **Uniform Assessment System for New York (UAS- NY)**
  Is a web-based application housed within the NYS Department of Health's, Health Commerce System (HCS). A comprehensive assessment system used in New York State for several Medicaid programs and Home and Community Based Services (HCBS) Waivers. For Health Home Serving Children, the UAS-NY houses the CANS-NY assessment for Plan of Care development and acuity payment, as well as the HCBS Children's Waiver eligibility assessment.

I. Policy

As specified in the New York 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 for individuals who have been deemed eligible and appropriate for the Health Home program. For more information, please refer to the Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016 policy.

Health Homes are to establish and maintain policies and procedures that define how and when the Comprehensive Assessment is completed for all consented Health Home members; the frequency at which the Comprehensive Assessment is conducted; clear and focused training on how the Comprehensive Assessment is administered; how various elements are obtained; and a quality assurance program to ensure compliance with specified requirements. The requirements for the Comprehensive Assessment, outlined in *Appendix A* of this policy, must be documented in the member's record, **Uniform Assessment System for New York (UAS- NY)** (Children), or in other identified locations within the Health Home's system and the requirement that all information collected through the Comprehensive Assessment is to be accessible to the Department, when required for Health Home Redesignation reviews or other purposes.

II. 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 is to inform a fully integrated Plan of Care. The Comprehensive Assessment includes:

- a screening tool that evaluates high risk behavior by the member or others 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

The Health Home Comprehensive Assessment identifies 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 assesses for risk factors that include but are not limited to the member's chronic conditions such as HIV/AIDS; harm to self or others; safety and well-being due to the behavior of 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 managers in their role of early identification, referral and linkage to clinical interventions for individuals at high risk of adverse outcomes. 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 provide training, guidance, and resource support for Care Management Agencies 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 are collected from systems and/or from different documentation gathered and stored in the electronic health record. The Health Home provides direction to support Care Management Agencies in understanding the link of each system and/or 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.

As part of the comprehensive assessment and person-centered planning with the individual, the Care Manager educates offers the member community-based services and programs that the member might benefit from and be eligible for, to address their identified needs. Additionally, the Care Manager helps to determine what referrals and connections to the services or programs are necessary.

To be eligible for the Children's Waiver Home and Community Based Services (HCBS), the member either must be at risk of institutionalization, or is being discharged from an institution and being referred to the Children's Waiver for the HCBS Eligibility

Determination to be conducted. It is the responsibility of the Care Manager to inform and educate the member/family about the HCBS, the potential benefits, and the eligibility process. After being educated regarding the purpose of HCBS (risk of institutionalization) and the eligibility process, if a member/family requests HCBS, the certified Care Manager would conduct the HCBS Eligibility Determination as appropriate. Please refer to *Children's Home and Community Based Services (HCBS) Waiver Enrollment Policy*.

If an adult served by a Health Home is enrolled in a Health and Recovery Plan (HARP) Medicaid Managed Care Plan or is a Health and Recovery Plan (HARP) eligible member enrolled in a HIV/Special Needs Plan, the Health Home Care Manager educates the member about BH HCBS and eligibility determination. If the member expresses interest in receiving BH HCBS, a Health Home Care Manager trained on the New York State Eligibility Assessment, or a qualified State designated entity administers the adult New York State Eligibility Assessment for Behavioral Health Home and Community Based Services. Please review the guidance, Revised Adult BH HCBS Workflow Guidance for HARP and HIV SNP Members Enrolled in Health Home.

III. Timelines for Completing Comprehensive Assessments

Certain timelines and requirements are attached to developing, completing, and updating a member's Comprehensive Assessment. These are established in this section, alongside additional information for requirements specific to only Health Homes Serving Adults or Health Homes Serving Children. The required components of the Comprehensive Assessment for all Health Home members (Adults and Children) are included in *Appendix A* of this policy.

A. Initial Comprehensive Assessment

For both Health Homes Serving Adults and Health Homes Serving Children, the initial Comprehensive Assessment is to be completed concurrently with an initial Plan of Care within fifty-six (56) calendar days of enrollment in order for billing to proceed.

An assessment may be completed over the course of several days; at least one (1) of these encounters during the initial assessment period will be in-person. Health Home policy clearly identifies required timeframes for completion of the initial assessment and Plan of Care and implement quality review of these timeframes to ensure adherence.

For Health Homes Serving Children

As part of the Health Homes Serving Children program, the CANS-NY which is housed in the UAS-NY is completed for enrolled Health Home members to determine Health Homes Serving Children decision model acuity, as well as to guide service planning specifically for children and adolescents under the age of twenty-one (21) with behavioral needs, medical needs, developmental disabilities and juvenile justice involvement. The CANS-NY and UAS-NY additionally serve as the tools used to collect the majority of the information needed for the required Comprehensive Assessment of members enrolled in Health Homes Serving Children.

While the CANS-NY can assist a Care Manager in identifying areas of needs and strengths, details of those needs and strengths may not be included within the CANS-NY and UAS-NY. 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 UAS-NY such as medications, types of treatments, and HIV/AIDS measures. Unless noted in the UAS/CANS-NY, this information is to be captured elsewhere in the member's Health Home electronic health record. The CANS-NY is to be used by the care manager to assess what are important areas to the child and family to focus on in the Plan of Care.

B. Annual Comprehensive Assessment

For both Health Homes Serving Adults and Health Homes Serving Children, the Comprehensive Assessment is completed annually based on the date of last completion.

For Health Homes Serving Adults
The Continued Eligibility for Services (CES) Tool, which provides the Health Home with decision support regarding continued enrollment in the Health Home program, is conducted twelve (12) months after the consent date, or the segment start date (whichever is later), and every six (6) months thereafter. The Comprehensive Assessment may inform the Continued Eligibility for Services (CES) Tool based on the risk factor(s) identified for the member's continued enrollment. Health Homes Serving Adults follow requirements outlined in the Guidance for Use of the Continued Eligibility for Services (CES) Tool. Depending on timing, information used to complete the Continued Eligibility for Services (CES) Tool may inform the annual Comprehensive Assessment.

For Health Homes Serving Children
The CANS-NY is completed annually from the date of last completion. When reviewing and updating the CANS-NY, the Care Manager reviews and updates the member's Comprehensive Assessment and Plan of Care.

C. Significant Life Events

For both Health Homes Serving Adults and Health Homes Serving Children, if the member experiences a Significant Life Event in medical and/or behavioral health or social needs before the next scheduled review, a Comprehensive Assessment is not necessary. However, the Health Home 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. Any changes in the member's goals or service needs should be reflected in the Plan of Care 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 Plan of Care should be reflected later in the annual comprehensive reassessment. For more information on Significant Life Events and the

Plan of Care, please refer to the Health Home Plan of Care Policy HH0008.

For Health Homes Serving Children
The Health Home Care Manager should also perform a CANS-NY reassessment when a Significant Life Event occurs. Care Managers must reference the UAS-NY for selection of one of the "Reasons for an Early Child Adolescent Needs and Strengths – New York (CANS-NY) Reassessment."

IV. Training

Health Homes should have clear operationalized policies and procedures that provide well-defined direction to Health Home Care Managers and Care Management Agencies regarding training for, and administering of, the Comprehensive Assessment. Health Homes are to 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, such as motivational interviewing, for increasing engagement. 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 choose to incorporate into their assessment process. It is not necessary to collect the information for the Comprehensive Assessment by asking the questions in a "checklist" format. As a HHCM becomes more familiar with the assessment process, they may engage in information collection through a conversational interchange.

V. Quality Management Program

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

- Comprehensive Assessment is administered within required timeframes (e.g. initial, annual, etc.)
- Documentation/verification has been obtained using various sources, including primary care provider (PCP), behavioral health and substance abuse provider, PSYKES, a Regional Health Information Organizations (RHIO), Statewide Health Information Network for New York (SHIN-NY), or Managed Care Organization (MCO) within thirty (30) calendar days
- Timely completion of Continued Eligibility for Services (CES) Tool (Adults)
- All required components are addressed
- Member's care team included during assessment process
- Supervisor was engaged for members/evidence of Significant Life Event
- For Children, timely completion of the Child Adolescent Needs and Strengths – New York (CANS-NY) and Uniform Assessment System (UAS)

Appendix A

Required Components of the Health Home Comprehensive Assessment

The requirements for the Comprehensive Assessment, outlined here in *Appendix A* of this policy must be documented in the member's record, UAS-NY (Children), or in other identified locations within the Health Home's system which are accessible to the Department, for Health Home Redesignation reviews or other purposes.

The Health Home consent form (DOH 5055 or 5201) includes all providers referenced through the Comprehensive Assessment, as well as the Medicaid Managed Care Plans, (MMCP) and Behavioral Health Organization (BHO) as applicable.

All topic areas listed below must be assessed. If there is an area that a member does not want to or is not able to provide substantive responses to, the CM is to note that within the case record. It must be clear in the member's care record that the HHCM made efforts to collect information across all topic areas or have proper documentation that they were not asked due to the age, developmental, or understanding of the member/parent/guardian. Health Home Comprehensive Assessment tools may incorporate "skip logic" allowing the Care Manager to move past components that may not be relevant in light of previous responses.

Documentation/verification for these components should be obtained from various sources, including a primary care provider (PCP), other care team members, PSYKES, a RHIO, Statewide Health Information Network for New York (SHIN-NY), or Managed Care Organization.

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
- Sickle Cell Disease (SCD)
- SED (Children)
- Complex trauma (Children)

Appropriateness for Health Home services

- Significant behavioral, medical, or social risk factors in addition to those noted within the initial Appropriateness (Adults and Children), yearly appropriateness (Children) and, the CES tool (Adults). For more information on initial and yearly appropriateness, refer to the Eligibility Requirements for Health Home Services and Continued Eligibility in the Health Home Program HH0016. For more information on CES Tool,

please refer to the Guidance for Use of the Continued Eligibility for Services (CES) Tool.

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
Was the child exposed to HIV perinatally or after birth?
Is member receiving PrEP and/or PEP?

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 situation

- Service use within the last 12 months
- Current functioning
- Symptoms and severity
- Diagnoses
- Dangerous/High Risk 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 Substance Use Disorder (SUD) using an Office of Addiction Services And Supports (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);
- How substance use/dependence affects daily living: (why the person takes substances, behavior problems, daily living skills, employment, relationships, finances, psychiatric symptoms, self-medication);
- Is the member aware of any adverse impact of substance use on their life?
- 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)

Referral to treatment needed?
Identify barriers to service

Developmental Disability

**Key relevant screening questions, motivational interviewing*

- Identified condition, diagnosis, etc.
  - Intellectual and/or developmental disabilities (I/DD)
  - Determination of Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IID) Level of Care Eligibility Determination (LCED)?
- Assessments conducted?
- Involvement of the Office of Persons With Development Disabilities,
- Current support
- Current services for IDD

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
- Specialist, type and purpose

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
*NOTE: Youths age fourteen (14) or older must have an independent living goal on their Plan of Care

Social service needs/ social determinants of health

**Key relevant screening questions, motivational interviewing*

Housing

- risk of eviction questions
- 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 Substance Use Disorder
- 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 medication 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
Schools/educational institutions
Home and Community Based Service providers
Peer support provider
Other community-based providers

Natural Supports

Family members
Friends
Faith based supports
Other individuals identified by the member