ST. JOSEPH'S HEALTH A Member of Trinity Health; ST PETER'S HEALTH PARTNERS A Member of Trinity Health	**Effective Date:** January 1, 2025

Category: **C. Care Coordination**

Title: **2. Assessment and Re-assessment**

Applies to:

☐ St. Peter's Health Partners (SPHP)

☐ All SPHP Component Corporations **OR** ☐ Only the following Component Corporations: (Click here for a list)
☐ _____

☐ All SPHP Affiliates **OR** only the following Affiliates: (Click here for a list)
☒ **All Community Health Connections Care Management Agencies**

☐ St. Peter's Health Partners Medical Associates (SPHPMA)

Contents

PURPOSE

This policy seeks to clarify when assessments need to be completed and documented for all enrolled Heath Home Members.

POLICY STATEMENTS

It is the policy of Community Health Connections to ensure that all enrolled Health Home Members are assessed at time of enrollment and annually thereafter. The assessment and re-

assessment(s) should drive the Plan of Care, meaning that needs identified in the assessment should be incorporated into the Plan of Care. Care Coordinators will conduct re-assessment at regular intervals to include newly developed needs and eliminate resolved needs as well as to ensure the continued appropriateness of Health Home services for the Member.

SCOPE OF AUTHORITY / COMPETENCY

All Care Management Agencies that comprise the Community Health Connections Health Home program.

DEFINITIONS

CES Tool: NYS-required screening for enrolled Members to ensure continued eligibility for the Health Home program

Comprehensive Assessment: An assessment tool that identifies the Members current medical, behavioral health, social service and substance abuse conditions and needs as well as history; the assessment defines services needs being addressed and by whom, services that have not yet been provided, barriers to services

Health Home Candidate: An individual who is in active Client Search (Outreach) status, but who has not yet been enrolled in Health Home services

Health Home Member: An individual who is enrolled in Health Home services

Initial Appropriateness Screening: NYS-required screening to ensure Members meet at least one appropriateness criteria at the time of enrollment or re-engagement from DSE or Excluded Setting

NYSDOH: New York State Department of Health; the regulating State entity for Health Homes

Re-assessment: The opportunity to review a Member's progress, consider successes and barriers and evaluate the previous period of care coordination activities; re-assessments can be useful in determining if the current level of services and model of care coordination is meeting the Member's needs or if changes need to be implemented to better meet the Member's needs

Screening Tools: a set of tools offered by CHC to be used to determine if a Member has additional needs and thus potentially requires referrals for those needs; screening tools are used for social determinant needs, substance abuse, mental health symptoms, suicidality and adverse childhood experiences

PROCEDURE

A. Initial Assessment and Screenings

1. Community Health Connection's Comprehensive Assessment and all of the appropriate Screening Tools (See Section B) must be completed within 30 days of enrollment with Health Home services.

2. An individual is considered an enrolled Health Home Member once Medicaid eligibility as well as Health Home eligibility and appropriateness have been determined and documented and the Member has agreed to participate in Health Home Services. (See Policy B2. Outreach and Engagement: Medicaid and Health Home Eligibility)

3. To help establish rapport with Members, Initial Comprehensive Assessments should be completed face to face with Members. However, at the request of the Member or family of the Member, the Initial Comprehensive Assessment may be completed telephonically. In these rare situations, the Member's request and assent for a telephonic or video meeting to conduct the Initial Comprehensive Assessment must be documented in the Member's chart in CareManager.

4. As part of the Comprehensive Assessment, advance directives must be discussed with Member's and their family, when appropriate. Outcomes of the discussion must be captured in the Long Terms Care section of the assessment in CareManager. If Member's request it, additional information on advance directives must be provided to the Member and his or her family, when appropriate.

5. The Comprehensive Assessment and accompanying Screening Tools are not required to be completed in one sitting. Care Coordinators and Supervisors should use their best judgment to determine if the assessment and tools should be completed over more than one visit.

B. Screening Tools

1. CHC's Screening Tools include the following: CAGE-AID, MMS, C-SSRS and ACEs. Not all Screening Tools are required for all Members.

2. Screening Tools must be completed at time of enrollment as described in A1 above. Screening Tools can be re-administered as needed, based on the Member's circumstances and the Care Coordinator's or Supervisor's concerns.

3. Not all Screening Tools are required to be completed. The chart below outlines, which Screening Tools are required and which are conditionally required. A CMA

may choose to require the use of Screening Tools that are listed below as Conditional or Not Required.

Required?	Assessment/Screening	Conditions / Notes
Yes	Intake Assessment	At time of intake only
	Initial Appropriateness Screening	At time of enrollment and when re-engaging from DSE or Excluded Setting
	Comprehensive Assessment	Updated annually
	SDOH Screening Tool	Updated annually
	CAGE-AID	Required at Intake, updated as needed, if at all
	CES Tool	Required 12 months post-enrollment and updated every six months thereafter
	HML Billing Questionnaire	Required each month
Conditionally	Modified Mini Screen MMS	Required at intake if not connected to BH services
	C-SSRS Assessment	Use if history or risk of suicidality, based on comprehensive assessment and Member reports
	HIV Assessment	Required if required by CMA
No	Adverse Childhood Experiences	Use as needed

4. The questions in the conditionally-required HIV Screening Tool are built into to CHC's required Annual Comprehensive Assessment / Re-assessment. The HIV Screening Tool is conditionally required as a stand-alone tool for agencies that choose to use the Screening Tool outside of the Annual Comprehensive Assessment/Re-Assessment.

5. The intention of the Screening Tools are to determine if the Member needs referrals to providers or if there are safety concerns. The five Screening Tools that are required or conditionally required have guidance on how to administer and score the tools to help determine if referrals or additional steps are needed to mitigate risk and increase Member safety. Attachment A of this policy provides more guidance on how to administer the tools, how to score and when next steps are warranted. Supervisors are strongly encouraged to review the results of the Screening Tools with staff to best determine next steps.

C. Re-assessments

1. The Comprehensive Assessment will be updated for each Member annually based on the date of the initial Comprehensive Assessment. Assessments may be updated more frequently if there is a significant change in the Member's health or behavioral health or social needs. Changes in the assessment will be reflected in the Plan of Care.

2. As a best practice, annual re-assessments should be completed face to face with Members. However, at the request of the Member or family of the Member, the re-assessment may be completed telephonically. In these rare situations, the

Member's request and assent for a telephonic or video meeting to conduct the re-assessment must be documented in the Member's chart in CareManager.

3. As noted in Section B2 of this policy, Screening Tools should be re-administered as needed based on Member circumstance.

D. Initial Appropriateness Screening

1. At the time of enrollment, the Initial Appropriateness Screening must be completed in CareManager. The single most critical or pressing appropriateness criteria must be select from the list. This information is required to ensure only those who are appropriate for services are enrolled in services. Information collected on the Initial Appropriateness Screening will be sent to NYS DOH. Without this information completed in CareManager billing will be rejected by NYS DOH.

2. In addition to the time of enrollment, the Initial Appropriateness Screening must also be completed anytime a Member re-engages and is moved back to enrolled status after being in DSE or Excluded Setting status for any length of time. (See Policy C6: Case Closure and Re-engagement)

E. CES Tool

1. Starting November 1, 2023, Members must have a completed CES Tool at the time of their first anniversary of enrollment in the program.

2. For Members enrolled prior to November 1, 2023, the first CES Tool will be completed at the time of the Member's next annual Comprehensive Re-assessment.

3. Once the first CES Tool is completed, the tool will be completed every six months thereafter.

4. Members exempt from this requirement include the following:
   a. Members on AOT,
   b. Members who are HH+ Eligible or HH+ Enrolled, as identified on Q12 of HML,
   c. Members in DSE at the time the CES Tool comes due, and
   d. Members in Excluded Setting at the time the CES Tool comes due.

5. The CES Tool does not need to be completed with the Member.

6. While the CES Tool can be completed by anyone, if a Care Coordinator completes the tool, supervisory review is required.

7. When a Member steps down from HH+ or AOT status to a traditional Health Home level of care, the CES Tool must be completed at the time of the first anniversary of step down, then every six months thereafter.

8. When a Member is moved back to enrolled status after DSE or Excluded Setting, the Initial Appropriateness Screening will be completed, then the CES Tool completion will resume six months following the completion of the Initial Appropriateness Screening.

9. The CES Tool must be completed in CareManager. Once all responses are inputted, a result will be populated automatically by the system. The following grid explains the outcomes generated and required next steps.

Continued Enrollment	Continue Care Coordination services and complete the CES Tool again in six months
More Information Needed	Further evaluation is needed with the Member or providers to determine a conclusive outcome on continued enrollment. Another CES Tool must be completed within 60 calendar days. The outcome of More Information Needed is not acceptable for the second CES Tool
Recommended Disenrollment	Member is required per NYS DOH to be discharged from the program within 60 days

10. Failure to comply with the 60-day follow-ups for an outcome of More Information Needed or Recommended Disenrollment will result in NYS DOH rejecting any billing past the 60 day mark.

F. Documentation of Assessments

1. All assessments must be entered directly into the Member's electronic health record in CareManager, including the complete Comprehensive Assessment, accompanying Screening Tools, Initial Appropriateness Screenings, CES Tools and all re-assessments.

2. Information from the Comprehensive Assessment, Screening Tools and annual re-assessments must be used to develop the Member's Plan of Care. This means that the Goal, Strengths, Barriers, Objectives and Interventions that create the Plan of Care should be based on the needs and other information collected during the intake, assessment and re-assessment process.

3. As re-assessments are conducted, any new information should be incorporated into the Plan of Care. This could mean creating new Member Objectives and

Interventions or updating the status of Objectives and Interventions that are in progress or achieved.

4. Supervisors should conduct reviews of any assessments for those Members deemed high risk or those who experience adverse events. These reviews can be documented as a Contact Note using the reason for contact as a Supervisory Review.

REFERENCES

New York State Department of Health (January 9, 2014). Health Home Provider Manual: Billing Policy and Guidance. (https://www.emedny.org/ProviderManuals/HealthHomes/PDFS/Health_Homes_Provider_Manual.pdf)

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Replaces: Documentation – Assessment, Reassessment and Plan of Care
Care Coordination: Assessment and Re-assessment (May 1, 2017)
Care Coordination: Assessment and Re-assessment (October 1, 2017)
Care Coordination: Assessment and Re-assessment (April 1, 2021)
Care Coordination: Assessment and Re-assessment (January 1, 2023)
Care Coordination: Assessment and Re-assessment (December 1, 2023)

ATTACHMENT A: Screening Tools Guidance

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The following pages provide explanation and guidance around administering and scoring the three CHC required or conditionally required Screening Tools, as indicated in the policy above.

CAGE-AID (CAGE Questions Adapted to Include Drugs)

- Required for all Enrolled Members
- Updated as needed, if at all
- Timeframe: Past six to 12 months

Using the CAGE-AID

The CAGE questionnaire is used to test for alcohol abuse and dependence in adults. The CAGE-AID version of the tool has been adapted to include drug use. These tools are not used to diagnose diseases, but only to indicate whether a problem might exist. The CAGE-AID is a sensitive screen for alcohol and drug problems. The key words of the four questions create the acronym CAGE.

C - Ever try to **Cut back** on your drinking or drug use?
A - Ever been **Annoyed** by anyone about your drinking or drug use?
G - Ever felt **Guilty** or ashamed about your drinking or drug use?
E - Ever had an **"Eye-opener"** or used alcohol or drugs in the morning?

Scoring the CAGE-AID

Item responses on the CAGE-AID are scored 0 for "no" and 1 for "yes" answers. A higher score is an indication of alcohol problems. A total score of 2 or greater is considered clinically significant, which then should lead the Care Coordinator to speak with their Supervisor on the appropriate next steps.

Modified Mini Screen (MMS)

- Required if not connected to behavioral health services
- Updated as needed, if at all
- Timeframe: Past six to 12 months

Using the MMS

The Modified Mini Screen (MMS) is a generic screening measure for mood, anxiety, and psychotic spectrum disorders. There are twenty-two questions with yes/no responses. It should take about 15 minutes to complete.

Scoring the MMS

To score the MMS, total the number of "yes" answers.

- A score of six or greater indicates the likely presence of a psychiatric disorder.
- A patient who answers yes to question 4 should be monitored for suicidality.

C-SSRS

- Use if history or risk of suicidality
- Updated as needed, if at all
- Timeframe: Past month, exception is the last question which asks for a timeframe

Using the C-SSRS

Questions 1 and 2 are screening questions; if the answers to both are negative, skip to the "Suicidal Behavior" section.
Questions 1-5 reflect five types of ideation of increasing severity, all of which are answered with "yes" or "no."

Scoring the C-SSRS

A positive answer to item 4 (active suicidal ideation with some intent to act) or 5 (active suicidal ideation with specific plan and intent) indicates that the individual has **some intent to act on suicidal thoughts** and will need further evaluation or clinical management depending on context/setting.

Endorsement of Ideation Severity items 1, 2 or 3 could also indicate a need for further evaluation or clinical management depending on population or context.

SDOH Screening Tool

Ten question screening tool required by NYS DOH. The tool asks Members about living situations, food, transportation, utilities, and safety. This tool is designed to identify where additional supports or referrals are needed.

A score of 11 or more on the last four questions (safety-related questions) indicate that the person may not be safe.