ST. JOSEPH'S HEALTH
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Community Health Connections Health Home
Screening Tool Guidance and Instructions

CareManager has several Assessments and Screening Tools in the Assessment Tab. The following matrix outlines when each Assessment or Screening Tool should be used.

Required?	Assessment/Screening	Conditions / Notes
Yes	Intake Assessment	At time of intake only
	Comprehensive Assessment	Updated annually
	SDOH Screening Tool	Updated annually
	CAGE-AID	Required at Intake, updated as needed, if at all
	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

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