Adirondack Health Institute

Lead Empower Innovate

**POLICY AND PROCEDURE**

***Title***: Comprehensive Assessment Policy

***Department***: Health Home

***Intended Population:*** Health Home Serving Adults and Children

***Effective Date***: 9/21/2015

***Review Date***: 2/27/19

***Date Revised***: 4/1/2019; 5/13/2019; 9/1/2019

**Purpose of Policy**

To establish standards and guidance regarding the Health Home Comprehensive Assessment.

**Scope**

This policy applies to all AHI Health Home Service Providers that serve Health Home participants, both adults and children.

**Statement of Policy**

AHI shall develop, disseminate, and review at least annually a Comprehensive Assessment Policy that addresses purpose, scope, roles and responsibilities, management commitment, coordination among organization entities, and compliance. AHI shall formalize documented procedures to facilitate the implementation of the Comprehensive Assessment Policy.

**Definitions**

***AHIHH:*** AHI Health Home, a designated lead Health Home by the New York State Department of Health

***Child***: A person age 21 or younger who is not on AOT (Assisted Outpatient Treatment) or in ACT (Assertive Community Treatment).

***Health Home Network Partners:*** The group of medical, behavioral, social services, and other community-based organizations by which a Health Home Participant receives services to address needs identified on the comprehensive care management plan developed by the Health Home Participant's AHI Health Home Services Provider.

***Health Home Participant:*** A Health Home Candidate who is participating in the AHI Health Home and is assigned to an AHI Health Home Services Provider for care management.

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***Health Home Service Provider:*** An organization that has a fully executed contract (the "Health Home Services Provider Agreement") with the Adirondack Health Institute to provide health home outreach and/or care management services.

***Care Management Record System:*** A structured information system, maintained by the Adirondack Health Institute Health Home (AHIHH), and made available for Health Home Service Providers and Health Home Network Partners to utilize, as applicable and appropriate to their role in the Health Home.

***Core Health Home Services:*** The list of five (5) approved categories of services for which a Health Home Care Management Agency can be paid, as defined by the New York State Department of Health:

- Comprehensive Care Management
- Care Coordination & Health Promotion
- Comprehensive Transitional Care
- Member & Family Support
- Referral and Community & Social Support Services

Note: the sixth category of Core Health Home Services, "The use of HIT [Health Information Technology] to link services, as feasible and appropriate," is NOT considered a billable activity.

***RHIO:*** Regional Health Information Organization

***HARP:*** Health and Recovery Plan

***HCBS:*** Home and Community Based Services

***Brief CMHA:*** Community Mental Health Assessment

***CANS:*** 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.

**Background**

The Comprehensive Assessment Policy at AHI is intended to facilitate the effective implementation of the processes necessary to meet the Health Home Program standards and requirements as stipulated by the NYS DOH, federal regulations, and best practices. This policy directs that AHI meet these requirements.

**POLICY**

It is the policy of the Adirondack Health Institute Health Home (AHIHH) that each Health Home member receives a comprehensive assessment **within the first 60 calendar days of enrollment.**

**Procedure**

**Comprehensive Assessment Elements**

- The Health Home Service Provider will create and maintain a comprehensive care management plan of care for each Health Home Participant, that addresses needs identified in the Comprehensive Assessment; the information collected must result in a fully integrated Plan of Care. The Plan of Care is covered in greater detail in AHI's Plan of Care Policy.

The Comprehensive Assessment will include but limited to:

- Medical
- Behavioral Health Services
- Rehabilitative
- Long Term Care
- Social Service Needs
- Substance Use
- Assess Risk factors that include: HIV/AIDS; Harm to self or others; persistent use of substances impacting wellness; food and/or housing

- The assessment can be completed over the course of several days, at least one of these encounters during the initial assessment period must be face to face. ***All questions in the Comprehensive Assessment require a response; not applicable (N/A) is not an acceptable response.***

- The Comprehensive Assessment will include:

i. Verification that an assessment of eligibility criteria (detailed below) and appropriateness for Health Home services has been conducted.
   - Two Chronic Conditions
   - SED/SMI
   - Complex Trauma (Children)
   - HIV/AIDS

ii. A screening tool that evaluates high risk behaviors that may jeopardize the individual's overall health and wellbeing.

iii. A detailed description of the members' medical and behavioral (mental health and substance use), as well as psychosocial conditions and needs.

iv. An assessment of social determinates 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.

v. Advance directives with enrollees and/or parent/guardian/legally authorized representative, if appropriate (example medically complex child, member with cancer, etc.)

vi. Self-management skills and functional ability (thinking and planning, sociability/coping skills, activity/interests).

vii. Identification of the member's strength's support system, and resources.

viii. For transition age youth, independent living skills/coping skills and transition to adult services.

ix. For toddlers and children, developmentally milestones and growth chart.

- The completion of the Health Home Comprehensive Assessment, with member consent, can be supported by gathering information from a variety of sources. AHIHH supports continuity of care and health promotion through the development of a supportive relationship with the individual and their care team. Team members can assist the care manager in providing historical information. Sources include:
  - Current Service Providers
  - Family and natural supports
  - Community Based Resources
  - Faith based organizations
  - Members self-report
  - CANS-NY (children)
  - Primary Care Provider (PCP)
  - Specialty Provider
  - PSYKES Database
  - HIXNY or other RHIO
  - Medicaid Managed Care Plan (MMCP)

- Upon completion of the comprehensive assessment it is best practice for all care managers to review during supervision for areas of concern for all members. In the case of a high-risk member, or if there is evidence of an adverse event, the care management supervisor must review and sign the assessment to ensure that proper steps are being taken to safeguard the member. In these cases, the Plan of Care should be reviewed to set forth goals to mitigate the identified risks.
- Consent must be obtained for all providers on the care team and those referenced in the Comprehensive Assessment, as well as the MMCP and Behavioral Health Organization (BHO) as applicable. Once the comprehensive assessment is finalized it should be shared with all providers that are notated on the 5055/5201 unless the member has explicitly stated that it should not be shared with one of the listed providers.

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**HARP Members**

An adult being served by a Health Home Service Provider may be 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 Manger must educate the member about Home and Community Based Services (HCBS) and eligibility determination. Once the member consents to the HCBS Eligibility Assessment, a Health Home Care Manager who meets the necessary qualifications should administer the assessment. All HARP Enrolled individuals (H1) must have the assessment completed in the Uniform Assessment System (UAS) for HCBS determination. *See Staffing Qualification Policy for more detail on requirements to administer the HCBS Eligibility Assessment.*

- The HCBS Eligibility Assessment must be completed in the UAS within 90 days of enrollment; however, as best practice the assessment should be completed within 60 calendar days to coincide with the completion with the Adult Health Home Comprehensive Assessment.
- The Assessment will need to be completed annually, including members who decline HCBS services
- The results of the assessment will need to be incorporated in the Care Management Record System.
- A HARP Plan of Care is not required in instances when and enrollee is ineligible for HCBS or declines HCBS offered though the assessment process.
- A HARP Plan of Care will be prepared for HARP members receiving HCBS services that meet the requirements established by CMS. Including the below elements:
    - Documentation of results of the Home and Community Based Services (HCBS) Eligibility Screen (e.g., Not Eligible, Eligible for Tier 1 HCBS only, Eligible for Tier 1 and 2 HCBS);
    - For Individuals eligible to receive HCBS, a summary of the HCBS Eligibility Assessment; and
    - For individuals eligible to receive HCBS, Recommended HCBS services that target the individual's identified goals, preferences, and needs.

**Children's Health Home Members**

For youth enrolled in AHIHH the Child and Adolescent Needs and Strengths – New York (CANS-NY) must be completed to determine acuity and to guide service planning. ***The CANS-NY does not replace the Comprehensive Assessment***. Completion of the Comprehensive Assessment helps the care manager gather additional details regarding the youth's situation and assist the care manager in having an overall awareness of the child and family. All member's enrolled in a Children's Health Home program must have the CANS-NY Assessment completed in the UAS. The CANS-NY assessment is covered in greater detail within AHI's CANS-NY Assessment Policy.

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### Frequency

The initial comprehensive assessment must be completed concurrently with an initial plan of care within 60 calendar days of enrollment for adults and children; unless the Health Home Participant has CDPHP for their Medicaid Managed Care Plan, in which case the comprehensive assessment must be completed within 30 days of enrollment.

i. The assessment can be completed over the course of several days, at least one of these encounters during the initial assessment period must be face to face.

ii. The assessment must be updated annually or earlier if the member experiences a significant change in medical, behavioral, or social health.

iii. Any changes in the member's goals or service needs should be reflected in the Plan of Care.

### Documentation

- The Adirondack Health Institute Health Home (AHIHH) will provide and maintain a structured, interoperable, Care Management Record System for all HHSP's. Each member's comprehensive assessment must be documented in the AHIHH Care Management Record System.

### Quality and Performance Improvement

AHIHH will periodically review HHSP compliance to policy and procedure via quality assurance audits.

Quality assurance 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 was included in the assessment process
- Supervisor was engaged for high risk members as evidenced by adverse events
- CANS-NY was utilized to assist with the comprehensive assessment and POC (children)

### Training:

This policy will be disseminated for review and questions before a policy training is given. If more time is needed outside of office hours a training will be developed to understand 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 to all care management staff.

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***Contact Person:*** Director, Health Home and Care Management

***Responsible Person:*** Health Home Service Provider

***Approved By:*** Chief Operating and Compliance Officer