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

Date Revised: 4/1/2019; 5/13/2019; 9/1/2019, 3/1/2021,6/1/2022,7/1/2023, 7/1/2024

DOH Policy Number: HH0002

Purpose of Policy

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

Scope

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- This policy must be distributed to all AHI Health Home program staff and all subcontracting Health Home Service Providers. All recipients of this policy must acknowledge their receipt and understanding of the policy by referring any questions, problems, or compliance issues with the policy within ten days of the issue date to the AHI's Health Home Assistant Director.

- All questions regarding this policy or its implementation may be directed to the Assistant Director, Health Home at AHI Health Home.

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.

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.

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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 and at least annually thereafter**

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. Any area of need identified in the Comprehensive Assessment is required to be addressed in the Plan of Care by the Health Home Care Manager unless the member chooses not to, and it is specifically documented in the member's record. *The Plan of Care is covered in greater detail in AHI's Plan of Care Policy.*

The Comprehensive Assessment will include but not limited to:

- Medical Needs; including access to Primary Care
- Social Determinates of Health
- Behavioral Health Services
- Rehabilitative
- Long Term Care
- Social Service Needs
- Substance Use
- Assessment of Activities of Daily Living
- Assess Risk factors that include: HIV/AIDS; Harm to self or others; persistent use of substances impacting wellness; food and/or housing
- Other wellness and health wellness needs that member would like to focus on (Documented in the Priorities Section)

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.

The Comprehensive Assessment will include:

i. Verification that an assessment of eligibility criteria (detailed below) and appropriateness for Health Home services has been conducted. *(This is captured in the Health Home Eligibility Screen under assessments in Netsmart.)*

- Two Chronic Conditions
- SED/SMI
- Complex Trauma (Children)

- HIV/AIDS
- Sickle Cell Disease

Appropriateness Criteria

- Unstable housing
- Lack of social/family supports/ disruption in family relationships
- Deficits in activities of daily living
- Non-adherence to treatments
- Inadequate connectivity with healthcare system and/or other systems of care
- Learning or cognitive issues
- Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
- At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)

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. As well as the member's need and current linkage to health promotion services.

viii. For transition age youth, independent living skills/coping skills (youth 14 and older) and transition to adult services (Youth 17 and older). These one or two elements **MUST** be addressed in the youth's Plan of Care.

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

x. For members 20 and under the child well visits (frequency dependent on age) must be documented, and the supporting documentation uploaded into the record; a copy of the current immunization record is also required to be up to date and on file in external documentation.

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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.

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 within the first 60 days 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 and at least annually thereafter. 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.

i. The assessment must be updated annually or earlier if the member experiences a significant change in medical, behavioral, or social health.
ii. 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 electronically documented in the AHIHH Care Management Record System.

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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, PSYCKES, a RHIO, or MCO within 60 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.

Contact Person: Assistant Director, Health Home

Responsible Person: Health Home Service Provider

Reviewed By: Director, Health Home and Care Management

Approved By: Chief Compliance Officer