FINAL DRAFT: DOH CES TOOL

Remember that the excel tool uses skip logic so that only a minimum number of questions must be answered

REMEMBER THE GOAL: WHAT ARE THE **MINIMUM NECCESSARY QUESTIONS TO DETERMINE** IF SOMEONE SHOULD "RECOMMEND CONTINUED ENROLLMENT", "RECOMMEND DISENROLLMENT", OR "MORE INFORMATION NEEDED"

THIS TOOL IS CURRENTLY BUILT IN EXCEL

MEMBER NAME	MEMBER CIN	CARE MANAGER NAME
LAST IN PERSON CONTACT WITH MEMBER (DATE)	**LAST CONTACT WITH AT LEAST ONE CARE TEAM MEMBER (DATE)**	**LAST COMPREHENSIVE REASSESSMENT (DATE)**
ELIGIBLE FOR HH+ SMI OR HH+ HIV?	**LENGTH OF STAY IN THEIR CURRENT HEALTH HOME PROGRAM (MONTHS)**	**TYPE OF STAFF COMPLETING THE TOOL (CARE MANAGER, SUPERVISOR, OR QUALITY ASSURANCE)**

AT THIS TIME THE CES TOOL SHOULD NOT BE COMPLETED FOR ANY MEMBER THAT IS ELIGIBLE FOR HH+

BASIC ELIGIBILITY PRE-SCREEN Any "No" answer ends the screening and generates a "Recommend Disenrollment" result. Any "Unclear" answer ends the screening and generates a "More Information Needed" result.	
Does the member have qualifying diagnoses for Health Home verified in the member record?	Yes/No/Unclear
Which one?	
Does the Member still have Active Medicaid, with no disqualifying R/E codes? Remember: Members can only be disenrolled due to inactive Medicaid if they are no longer eligible for Medicaid or if they have been refusing to take the necessary steps to fix the Medicaid case. It is expected that HHCM's will need to help members reactivate their Medicaid at times.	Yes/No/Unclear

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SIGNIFICANT RISK FACTORS Selection of at least one Concrete Example skips straight to Member Engagement Selection of "No Concrete Example of a Significant Risk Factor in record" skips straight to Additional Risk Factors.	
Does member currently have a concrete example of a Significant Risk Factor?	*SINGLE SELECT* ○ ADVERSE EVENTS RISK: Current Quality flag in PSYCKES or equivalent from RHIO or MCO ○ ADVERSE EVENTS RISK: Current POP flag in PSYCKES ○ ADVERSE EVENTS RISK: Current H-code in EMEDNY (HARP Eligible/Enrolled) ○ SOCIAL DETERMINANTS RISK: Currently homeless (HUD 1, 2, or 4) ○ SOCIAL DETERMINANTS RISK: Member has fewer than 2 people identified as a support by the member ○ SOCIAL DETERMINANTS RISK: Member has had a recent change in guardianship ○ SOCIAL DETERMINANTS RISK: Recent institutionalization or nursing home placement of member's primary support person ○ SOCIAL DETERMINANTS RISK: Member does not have needed benefits (SSI, SNAP, etc.) ○ SOCIAL DETERMINANTS RISK: Currently cannot access food due to financial limitations or ability to shop or access food site, dietary restrictions, etc. ○ SOCIAL DETERMINANTS RISK: Current Intimate Partner Violence ○ HEALTHCARE RISK: Member does not have a healthcare provider or specialist to treat a chronic health condition ○ HEALTHCARE RISK: Member has not seen their provider (e.g., PCP, BH, etc.) in the last year ○ HEALTHCARE RISK: Member (or guardian) is unable to appropriately navigate the healthcare system for the member's chronic conditions. ○ TREATMENT NON-ADHERANCE RISK: Member/care team member report of non-adherence…Must specify WHICH medication(s) and/or treatment(s) are involved. ○ TREATMENT NON-ADHERANCE RISK: PSYCKES flag related to non-adherence or equivalent from RHIO or MCO ○ RE-ADMISSION/RECIDIVISM RISK: Released from inpatient Medical, Psych, or Detox within the last 6 months. Must specify name of institution and date of release. ○ RE-ADMISSION/RECIDIVISM RISK: Released from Jail/Prison or other justice program within the last 6 months. Must specify name program and date of release. **No Concrete Example of a Significant Risk Factor in record – PROCEED TO ADDITIONAL RISK FACTORS**
Description/Specifics if indicated:	FREE TEXT, only required if one of the Examples that says "must specify" is selected

ADDITIONAL RISK FACTORS Questions in this section DO NOT have to be answered in order. Once the tool skips to another section or generates a result, STOP answering questions about risk factors.	
GENERAL RISK FACTORS Any "Yes" answer skips straight to Member Engagement Any "Unclear" answer ends the screening and generates a "More Information Needed" result. If all answers are "No", proceed to Stability Risk Factors	
Has member had preventable or unnecessary hospitalizations or ER visits over the last six months? *"Preventable" means they were directly attributable to their lack of adherence to or access to treatments, appointments, or understanding of their Chronic Diagnoses.* *"Unnecessary" means the health care need could or should have been met in an outpatient or urgent care setting instead.*	Yes/No/Unclear
Is the member's current housing unsafe?	Yes/No/Unclear
The member has safety concerns in their environment or community, and the member has not been able to follow a safety plan.	Yes/No/Unclear
Has the member been a danger to themselves or others within the last six months? *Examples: Suicidal or homicidal ideation or attempts, violence towards self or others, inclusive of self-harm or arson, subject of a temporary restraining order, etc.*	Yes/No/Unclear
STABILITY RISK FACTORS Any highlighted answer skips straight to Member Engagement Any "Unclear" answer ends the screening and generates a "More Information Needed" result. If there are no "Unclear" answers, and no highlighted answers, proceed to Skills Based Risk Factors	
If the member has a mental health diagnosis, have they experienced an increase in symptoms, or the need for crisis management responses within the last six months? *Crisis management could be provided through a formal crisis response team, or informally through their HHCM.*	Yes/No/Unclear/N/A
If the member has a SUD diagnosis, has the member met and maintained their SUD goals over the last six months, such as Abstinence, Moderation, or Harm Reduction? *SUD applies to legal and illegal drugs of abuse, alcohol, and/or tobacco if the member has identified a goal related to use of that substance.*	Yes/No/Unclear/N/A
Has the member had stable housing over the last six months? *This means there have been no evictions, moves, or periods of homelessness.*	Yes/No/Unclear
If the member is in a relationship with chronic Intimate Partner Violence, have they been able to follow a Safety Plan over the last six months?	Yes/No/Unclear
If the member is involved in the Criminal Justice System, have they been following the requirements of their Parole/Probation over the last six months?	Yes/No/Unclear/N/A
SKILLS-BASED RISK FACTORS Any "No" answer skips straight to Member Engagement Any "Unclear" answer ends the screening and generates a "More Information Needed" result. If all answers are "Yes", this ends the screening and generates a "Recommend Disenrollment" result. *These questions should be answered as if the member did not have HHCM assistance. Some people may have assistance from someone else in their life such as family, home aides, or other types of case managers, which we are referring to collectively as "a caregiver".*	
Does the member or caregiver understand the frequency of outpatient follow up, schedule and keep their healthcare appointments, and have reliable transportation to get to their healthcare appointments without HHCM assistance?	Yes/No/Unclear
Does the member or caregiver understand who is on their Care Team and when/why/how to contact them without HHCM assistance?	Yes/No/Unclear
Does the member or caregiver maintain the member's medication adherence without HHCM assistance?	Yes/No/Unclear
Is the member or caregiver aware of upcoming recertifications for benefits and can successfully recertify without HHCM assistance? *This could include Medicaid, SNAP, SSI, SSDI, Public Assistance, etc.*	Yes/No/Unclear

Does the member or caregiver manage the member's day-to-day finances without HHCM assistance?	Yes/No/Unclear

ENGAGEMENT

Any "No" answer ends the screening and generates a "Recommend Disenrollment" result.
Any "Unclear" answer ends the screening and generates a "More Information Needed" result.
A "Yes" answer for ALL THREE questions ends the screening and generates a "Recommend Continued Services" result.

Members with legal guardians may not be able to engage actively with the HHCM, and progress on HH POC goals may look different than for other members.
For example: A member with severe dementia may not be able to talk directly to the HHCM, and the HHCM's primary engagement may be with the member's son or daughter.
The "Member Engagement" questions may be considered as "Caregiver Engagement" questions in these cases.

Does the member have non-maintenance goals left to accomplish on the POC? *An active (non-maintenance) goal is one that requires actions by the HHCM to elicit progress towards completion of the goal. The members' goal(s) would not be achieved without concrete interventions and support of the HHCM.* *Maintenance goals are goals that the member has met, and although ongoing, do not require any active assistance from the HHCM. Example: "Member will continue to fill their medication monthly".*	Yes/No/Unclear
Has the member been actively engaged and working with the CM on their HH POC Goals and Tasks in the last six months? *A member is not actively engaged if they are only in touch with the HHCM to say they are busy, or will call them back, or if regularly, Core Services being provided are only being provided through the Care Team because the member is unavailable.* *A member is not working with the HHCM on their HH POC Goals and Tasks if during their contacts they are solely updating the HHCM on their life or persistently addressing something not on the POC.*	Yes/No/Unclear
Have the member and Care Manager been making progress on their HH POC Goals and Tasks in the last six months? *A member is and HHCM are not making progress on the HH POC Goals and Tasks if the same task is being attempted month after month and nothing changes or moves forward.*	Yes/No/Unclear

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RECOMMENDATION	
Recommendations:	*AUTO-GENERATED BY THE TOOL* o Recommend Continued Services o Recommend Disenrollment o More Information Needed

Comments	*Free Text*

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