NEW YORK STATE | Department of Health | Medicaid Redesign Team

Health Home Comprehensive Assessment Policy Training

June 28, 2017

Today's Objective

- Overview of revised Comprehensive Assessment
- Define Comprehensive Assessment
  - What is assessment?
  - What do we mean by standardizing the assessment process?
  - What it is not?
- Responsibilities and accountabilities
  - Care Manager
  - Health Home
- Ongoing training and supervision
- Quality monitoring and oversight

Overview of Revised Comprehensive Assessment

- Gathered key stakeholders to form subcommittee to review and determine best ways to standardize comprehensive assessment across Health Homes
- Scope of subcommittee was to determine the common denominators that must be present in all Health Homes Comprehensive assessment
- Clearly articulate the importance of assessment as a care management skill and a process of information gathering to determine next steps.
- Delineate and clarify NYS expectations and respecting the boundaries and focus of care coordination over clinical interventions

Defining Assessment

Health Home Standards of Practice mandate a comprehensive assessment:

A comprehensive health assessment that identifies medical, behavioral health (mental health and substance use) and social service needs is developed (NYS State Plan Amendment 14-0016)

- ✓NYS Requires:
  - ❑An evaluation of a member's health care and related social and economic needs
- ✓NYS Expects
  - ❑Care Managers will provide an ongoing, dynamic process of information gathering to meet Health Home member's needs

Care Managers Responsibility

Assessing for Risk Factors
- HIV/AIDS
- Harm to self or others
- Persistent use of substances impacting wellness
- Food or housing insecurity
- Service and resource needs requiring referral
- Gaps in care and barriers to service access

Identification:
- Strengths
- Goal
- Resources available to enhance care coordination

Identify service needs currently being addressed
- Current service providers
- Family, natural supports
- Community based resources
- Faith based organizations
- Member self report

For HARP members, or HARP-eligible enrolled in HIV/Special Needs Plan:
- Care manager should educate member regrading BH HCBS, eligibility
- With consent, qualified care manager must administer NYS Eligibility Assessment for BH HCBS

Care Managers must document

- Verification that the individual meets eligibility and appropriateness criteria
- Screening tools that were used to evaluate high risk behavior
- A detailed description of the member's medical and behavioral health, as well as psychosocial conditions and needs
- An written evaluation of social determinants, lifestyle behaviors, social environment, health literacy, communication skills and care coordination needs such as entitlement and benefit eligibility and recertification
- Self management skills and functional ability, and
- The member's strengths, support system, and resources.

- ✓ The Care manager is fully responsible for assessment process including required documentation
- ✓ Care team can assist with historical information, reviewing assessment outcomes
- ✓ DOH 5055 must be completed
  - ➢ Should include all providers
  - ➢ Should include MMCP and BHO

Health Home Responsibility

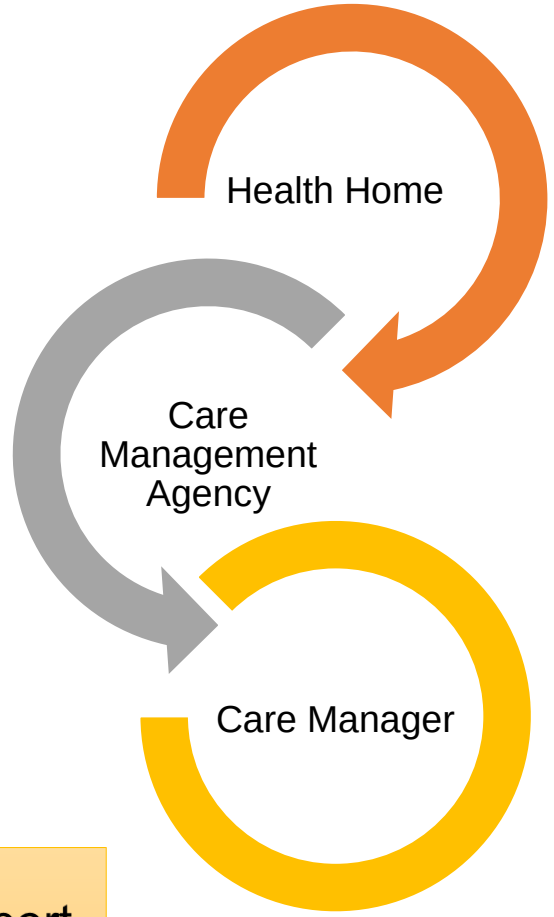
How and when a comprehensive assessment is completed for all *consented* HH members

The frequency at which the assessment will be conducted

Clear and focused training on how the assessment will be administered

The documentation process that identifies medical, mental health, chemical dependency and social service needs, and

A quality assurance program to ensure compliance



Health Homes must provide training, guidance, and resource support for CMAs to support early identification of risk factors

Frequency

Initial comprehensive assessment completed concurrently with initial Plan of Care within 60 days of enrollment.

- Complete over the course of days
- At least one face-to-face encounter
- HH policy must clearly define completion timeframes
- Quality review will ensure compliance

An annual reassessment is required.

What if member experiences a significant change?

- A full comprehensive assessment is not necessary
- Care manager should perform abbreviated evaluation
- Supervisor should review and sign off
- Changes to member goals, service needs noted in POC
- Case review with supervisor and care team
- Significant changes should be reflected in next annual reassessment

Training

Health Homes should have clear, focused, operationalized policies and procedures with well-defined direction regarding training for comprehensive assessment.

- The purpose and function of assessment
- How the assessment will be administered
- Recovery oriented, person-centered care planning
- Evidence-based methods for increasing engagement

Quality Management Program

Health Homes must have a quality assurance process in place to ensure that care managers and care management providers comply with policies and procedures.

- ✓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 included during assessment process
- ✓Supervisor was engaged for high risk members/evidence of adverse event

Required Components

- ❑Identification Information
- ❑Health Home eligibility/appropriateness criteria
- ❑HIV/Aids
- ❑Mental Health Services
- ❑Substance Use Disorder
- ❑Medical Health Care
- ❑Independent Living Skills
- ❑Social Service Needs
- ❑Vocational/Educational Status
- ❑Medications
- ❑Providers

Each area must be addressed.
A lack of response indicates the assessment is incomplete.

Source of Information

- Where information can be obtained and transferred from other HH assessments or evaluations, it can be used to populate the comprehensive assessment.
- Health Home should provide direction in understanding link of each document, how it fulfills assessment requirements

The information collected must result in a fully integrated plan of care

Comprehensive Assessment – HHSC, Next Steps

- The DOH has received feedback regarding from State Partner Agencies and HHSC
- A number of questions surrounding the policy and requirements
- A meeting will be scheduled in early July 2017 with HHSC and State Partner Agencies
- Expected completion date for the final Comprehensive Assessment for HHSC - July 31, 2017

A copy of the Health Home Comprehensive Assessment can be found on the Health Home Website.

For questions, please call the Health Home Helpline at 518-473-5569, or email at https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action, subject Health Home Policy