ENCOMPASS FAMILY HEALTH HOME
Care Management
Policy & Procedure Manual

Care Management Policy #5 Assignment to Care Manager –Enrollment/Assessment

Effective Date: 9/24/13
Revised Date: 10/22/15, 3/1/16, 9/1/16, 10/1/16, 11/1/16, 3/2/17, 3/29/17

Policy: Encompass Health Home Care Management will engage with enrolled Health Home Participants/Families, and define their Health Home service needs through a comprehensive Family Focused, strength based assessment process.

Procedure:

A. Upon assignment to a Care Management Agency/Program (CMA), the Candidate/Participant/Family will be assigned to Outreach Staff/Care Manager within 2 business days.
    1. Care Managers will be assigned based on experience, taking into consideration the Candidate/Participant's/Family's needs and eligibility based on the presence of issues including but not limited to Mental Illness(SMI); Serious Emotional Disturbance (SED); Complex Trauma; Substance Use Disorders; Co-Occurring medical Conditions; HIV, known risks and service use.
    2. CMAs will assure that assigned Care Managers do not have a financial interest or other existing relationship with a Participant/Family that would present a conflict of interest.
    3. The Care Manager will be responsible for overall management of a Participant's Plan of Care including communicating with providers, caregivers, supports and coordinating services.
    4. Care Managers will be provided all Candidates/Participants/Families information, completed assessments and consents.
    5. Care Managers will access available Health Information Technology to obtain additional client data required for assessment and Care Management activities.
    6. If no previous contact between Care Manager and Participant/Family, Care Manager will initiate a meeting with enrolled Participants/Families within five business days, by contacting Participant/Family by face to face visit and/or telephone (and letter if necessary).
B. The referral source will be notified within 48 hours of assignment to the CMA, to identify the CM, and to obtain additional information that may assist in serving the child/family. Notification will be clearly documented in Netsmart.
C. At initial meeting with enrolled Participant/Family, Care Manager will begin assessment through an interview process:
    1. Additional information regarding care management will be provided.
    2. An interactive discussion regarding Participant/Family continued interest in care management will be initiated.
        i. If Participant/Family no longer shows an interest in care management services, Care Manager will consult with Supervisor or other designated staff for guidance, and will consider engaging available supports such as Family and Youth Peer supports as needed.
    3. Participant/Family will be encouraged to share relevant information/history, expectations, preferences and goals of Care Management.

i. This will include but is not limited to communication preferences, cultural and language needs, and involvement of current support network.
   a) Care Management Agencies will utilize interpreter services and translated documents as needed to communicate with and share relevant information with the Participant/Family.
   b) The Health Home will assist Care Management Agencies with contracting with Language Services Associates (LSA) for phone/video interpretation and document services if needed.
   c) The Participant's MCO may be contacted to assist with obtaining information and available cultural resources available through their network of services.

ii. Participant/Family involved with an educational institution, may be asked to provide consent to educational records, by signing the Health Home Consent Information Sharing Release of Educational Records form (DOH-5203).
   a) All consents will be scanned and attached to the Plan of Care in Netsmart.
   b) Consent for Participants under the age of 18 must be obtained from a parent/guardian.
   c) Participants 18 or older will sign their own consents.

4. Care Manager will ensure Participants/Families engagement in the interdisciplinary team.
5. CANS-NY Assessments may begin at first appointment.

D. A **CANS-NY Assessment** that identifies medical, behavioral, chemical dependency and social service needs/ supports will be conducted and completed within 30 days of enrollment.
   1. Care Managers will obtain consent from Participant/Parent/Consenter to initiate the CANS-NY Assessment, by completing the DOH-5230 Functional Assessment Consent.
   2. Participants/Families will be offered and encouraged to include Peers, Family Advocates, Parent Partners or other family supports through a Family Wraparound process during the assessment and Plan of Care phases.
      i. The involvement of Family Support Workers during the assessment phase may include the use of a Family Assessment of Needs and Strengths (FANS) to address Parent's/Caregiver's individual strengths and needs.
      ii. When completing the CANS-NY assessment, Care Managers will schedule and hold the initial Care Team Meeting during the 30 day assessment period, to include those individuals identified on the consent, and any other supports identified by the Participant/Family relevant to the assessment process.
      iii. Care Managers will facilitate a Wraparound meeting, utilizing a strength based approach to addressing Participant/Family concerns.
         a) The Care Manager will direct the meeting by initiating discussion regarding the strengths, accomplishments and

interests of the Participant/Family, and then guiding the Participant/Family and Care Team members through a discussion of the Participant's/Family's needs.

3. Assessments will at a minimum, address the following areas:
    i. Physical Health/Clinical History, including visual and hearing needs and risk factors;
    ii. Mental/Emotional Health, Trauma and Cognitive Functioning;
    iii. Medications;
    iv. Chemical Abuse/Dependency;
    v. Housing, Transportation, Finances, Safety, Legal Issues, Employment/Education;
    vi. Assessment of ADL's;
    vii. Family Supports;
    viii. Relationships and Community Involvement;
    ix. Current Providers;
    x. Presence of Advanced Directives;
    xi. Barriers, Strengths and Preferences, including Cultural and linguistic needs.
4. Based on the CANS-NY Assessment, additional assessments can be indicated as necessary to identify specific physical and/or behavioral health risk areas.
    i. When indicated, additional assessments will be conducted including risk assessments/screenings for Substance Use; HIV Risk or Rehabilitative Care.
        a) Care Managers will conduct these assessments, or Participants will be referred to specialized providers to conduct additional assessments or risk screenings.
    ii. Care Managers will be trained on the use of the Screening, Brief Interventions and Referral to Treatment (SBIRT) evidenced based tools to assess and intervene for substance use and/or other high risk behaviors.
        a) Care Managers will incorporate the use of SBIRT in the assessment process with all Participants.
        b) Care Managers will utilize the CRAFFT screening tool for Children12- 21 to assess for high risk alcohol and other drug use.
        c) If indicated, referrals will be made to providers to address identified risk areas.
    iii. If the CANS-NY Assessment indicates possible depression, the Patient Health Questionnaire (PHQ-9) assessment will be completed in Netsmart, for children 12 and up.
    iv. The Health Home will provide assistance and training resources for additional assessment tools as needed.
5. Children's CANS-NY assessments will be conducted at a minimum every 6 months from the first day of the month it was completed, or as needed, based on significant changes in functioning, improvements or transitions.

i. Reasons for early reassessment can include recent admission, discharge or transfer from hospital, residential placement or Foster care; achievement of goals; serious injury/accident; change in caregiver, or their capacity/situation; court request.
ii. Additional documentation will be obtained and attached to the Plan of Care to support the CANS-NY assessment and subsequent HML rating.
iii. Early CANS-NY re-assessments will occur within 30 days of the documented significant event.

6. Completed assessments will be attached to the Plan of Care in Netsmart for view by Providers/Supports.
7. Care Managers will document a summary of the CANS-NY and the results of the assessment process in a note(s) in Netsmart.
8. A Comprehensive Plan of Care including Participant/Family goals will be developed based on the CANS-NY.
9. The Plan of Care will be a living document that may change as needed to align with the Participant's/Family's preferences, needs or goals, updated assessments, discharge criteria and/or changes in condition.