DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

May 10, 2017

Mr. Jason Helgerson
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Mr. Helgerson:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the evaluation design for the Health and Recovery Plans (HARP) component of New York's section 1115 Medicaid Redesign Team Demonstration (Project No. 1 l-W-00114/2). We have determined that the submission meets the requirements set forth in the Special Terms and Conditions and we approve the HARP evaluation design.

Your project officer, Deborah Steinbach, can be reached by phone at (410) 786-7404, or by e-mail at Deborah.Steinbach@cms.hhs.gov, should you need to contact her. We look forward to continuing to work with you and your staff on your 1115 demonstration.

Sincerely,

/s/

Angela D. Garner
Director, Division of System Reform Demonstrations

Evaluation Framework for the New York State Behavioral Health Partnership Plan Demonstration Amendment –
NYS MMC Behavioral Health Carve-In and Health and Recovery Plans
Demonstration Period: October 1, 2015 through December 31, 2020

In 2015, the State amended its current 1115 waiver demonstration to enable qualified Managed Care Organizations (MCOs) throughout the State to comprehensively manage Behavioral Health (BH) benefits for eligible recipients. These benefits will be met in the following ways:

- **Mainstream Medicaid Managed Care (MMC) Plans:** All adult recipients who are eligible for Medicaid Managed Care (excludes Medicare recipients and certain other populations), will receive the full medical and BH benefit through managed care. Plans began to cover expanded BH benefits in October 1, 2015. The expanded benefit includes services which the MMC plans previously managed for the non-SSI population (Psychiatric inpatient and Psychiatric clinic services), services that were covered only via the Medicaid Fee For Service (FFS) program (ACT, PROS, IPRT, SUD Inpatient and Clinic, Partial Hospitalization, CPEP, Opioid treatment, Outpatient chemical dependence rehabilitation), and new services (licensed behavioral health practitioner and behavioral health crisis intervention services).

  Also effective October 1, 2015 consumers enrolled in a MMC whose BH benefit was covered under FFS Medicaid through SSI will begin receiving these benefits through the MMC plan.

- **Health and Recovery Plans (HARPs) and HIV Special Needs Plans (HIV SNPs):** Adults enrolled in Medicaid and 21 years or older meeting the serious mental illness (SMI) and/or SUD targeting criteria and risk factors (see Appendix A) were passively enrolled into HARPs following the same timeline as the MMC behavioral health integration. These specialty lines of business operated by the qualified mainstream MCOs (MMMC) are also available statewide. Individuals meeting the HARP eligibility criteria who are already enrolled in an HIV SNP remained enrolled in their current plan but will receive the enhanced benefits of a HARP. In addition, HARPs and HIV SNPs will arrange for access to a benefit package of Home and Community Based Services (HCBS) for members who meet defined functional needs criteria. HARPs and HIV SNPs will work with Health Homes, or other State designated entities, to develop a person-centered care plan and provide care management for all services within the care plan, including HCBS.

The Behavioral Health demonstration was phased in with New York City (NYC) transitioning starting in October 2015 and rest of state (ROS) in July 2016 for adult enrollees (ages 21 to 64). Behavioral Health Home and Community Based Services were offered beginning in January 2016 in NYC and in October 2016 for ROS. The aims of the New York BH demonstration are to improve the NYS Medicaid BH population's health care quality, costs, and outcomes and to realize transformation of the BH system from an inpatient focused system to a recovery focused outpatient system. New York will conduct

a multi-method, comprehensive statewide evaluation using an independent evaluator to document the impact of both the Mainstream Managed Care carve-in of behavioral health specialty services and the HARP implementation on health care service delivery, quality, health outcomes, and cost effectiveness of the HARP. In addition, program components that posed particular successes or challenges for implementation and outcomes for this population will also be examined. The broad goals of the New York HARP evaluation are to assess the impact of the demonstration on: 8) Improvement in health and behavioral health outcomes for adults in Mainstream Medicaid Managed Care whose behavioral health care was previously carved out in a fee for service payment arrangement; 9) Improvement in health, behavioral health and social functioning outcomes for HARP enrollees and 10) Improvement in recovery, social functioning and community integration for individuals in the HARP meeting HCBS eligibility criteria.

Toward these goals, the following evaluation questions will be addressed:

Goal 8: Improve health and behavioral health outcomes for adults in Mainstream Medicaid Managed Care (MMMC) with behavioral health conditions

1. To what extent are MMMC enrollees with behavioral health conditions accessing community based behavioral specialty services[1], including ACT, PROS, and first episode psychosis programs?
2. To what extent are MMMC enrollees with behavioral health conditions accessing primary care, preventive services, or integrated health/behavioral health care?

Goal 9: Improve health, behavioral health and social functioning outcomes for HARP enrollees

1. How has enrollment in HARP plans increased over the length of the demonstration?
2. What factors are associated with individuals choosing to opt out of HARP plans?
3. What are the demographic, social, functional and clinical characteristics of the HARP* population? Are they changing over time?
4. What are the educational and employment characteristics of the HARP* population? Are they changing over time?
5. To what extent are HARP* enrollees accessing primary care?
6. To what extent are HARP* enrollees accessing community based behavioral specialty services?
7. To what extent are HARP enrollees accessing community based health care or integrated health/behavioral health care?
8. To what extent is HARP quality of care improving, especially related to HEDIS®/QARR measures of health monitoring, prevention, and management of chronic health conditions?
9. To what extent are HARP* enrollees experiences with care and access to health

and behavioral health services positive?

10. To what extent are HARP* enrollees satisfied with the wellness and recovery orientation, cultural sensitivity and their degree of social connectedness?
11. To what extent are HARPs cost effective? What are the PMPM cost of inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox and emergency room services for the HARP population? Are these costs decreasing over time?

Goal 10: Develop Home and Community Based services focused on recovery, social functioning, and community integration for individuals in HARP meeting eligibility criteria

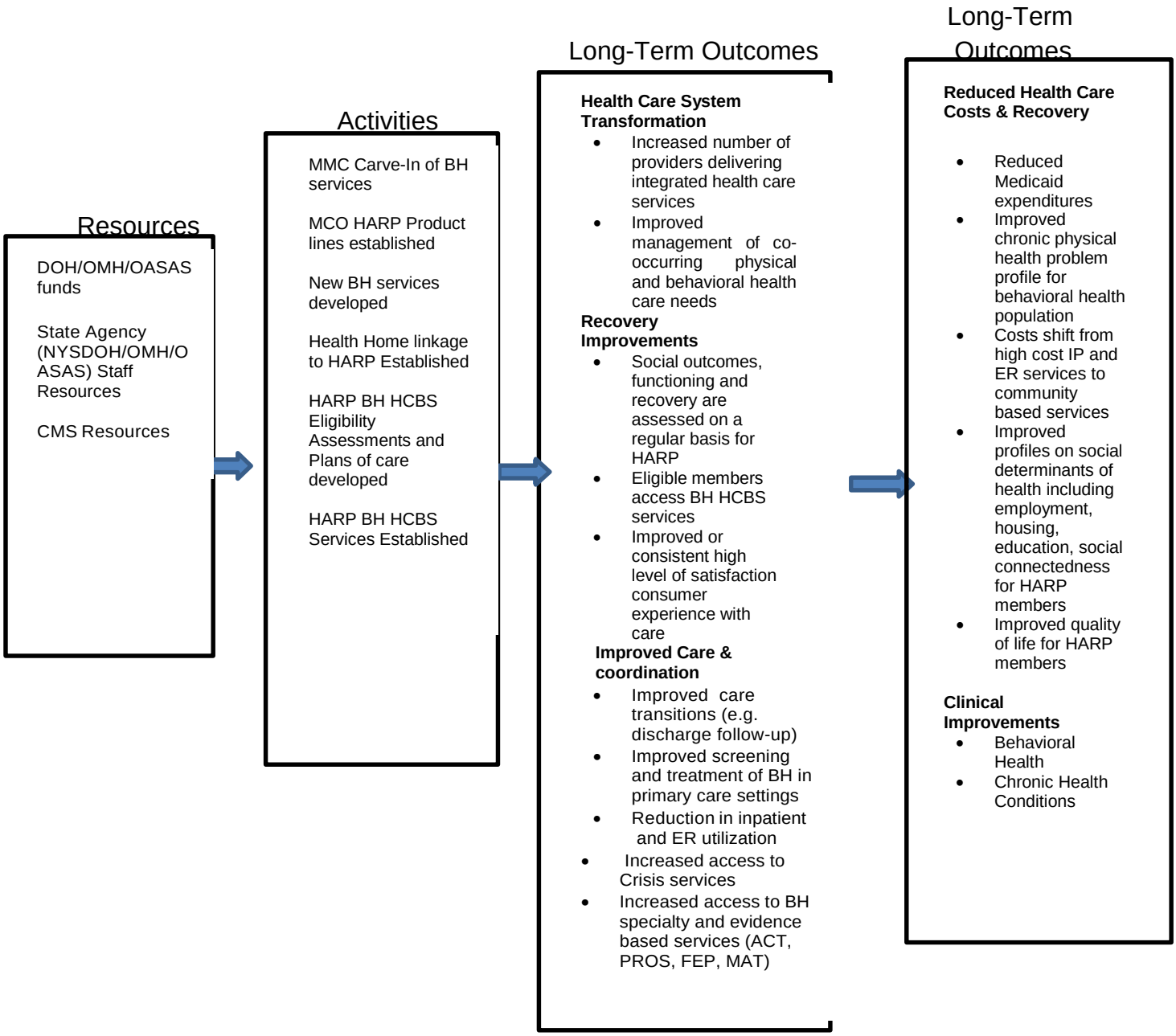
1. Access to Care: How many HARP enrollees become eligible to receive Home and Community Based Services? How many HCBS eligible enrollees go on to receive Home and Community Based Services?
2. Access to care: What are the consequences of targeting availability of BH HCBS to a more narrowly defined population as compared to the HARP eligibility criteria in the State Plan?
3. Costs: What are the PMPM costs of BH HCBS for HARP* enrollees who receive services?

Evaluation Framework

New York will conduct an end of demonstration period evaluation of the HARP. The proposed evaluation is a multi-method and robust statewide plan designed to examine the impact of the behavioral health demonstration on health care service delivery, quality, health outcomes, and cost effectiveness of the HARP, as well as to determine program components that posed particular successes or challenges for implementation and outcomes. The evaluation plan would be finalized in an agreement with an independent evaluator.

Figure 1 shows a logic model depicting the BH demonstration in NYS which identifies the expected short term activities, and intermediate and long-term program outcomes and provides a guiding framework for the evaluation. Although intermediate outcomes are expected, these will be formally evaluated at the end of the demonstration. The evaluation will use quantitative methods to assess program outcomes statewide and by region (NYC and ROS), and will also track outcomes over time. Some outcomes will also be compared across plan type (e.g., MCO Mainstream, MCO HARP and MCH HIV SNP levels). Survey methods will be used to assess consumer experience with care and consumer perception of care. Qualitative methods will be used to provide context for the quantitative and survey findings, as well as to obtain insights on HARP program functioning and effectiveness from administrative, provider, and patient perspectives. Evaluation methods and data sources (Appendix D) are detailed in sections to follow.

Figure 1: NYS Logic Model



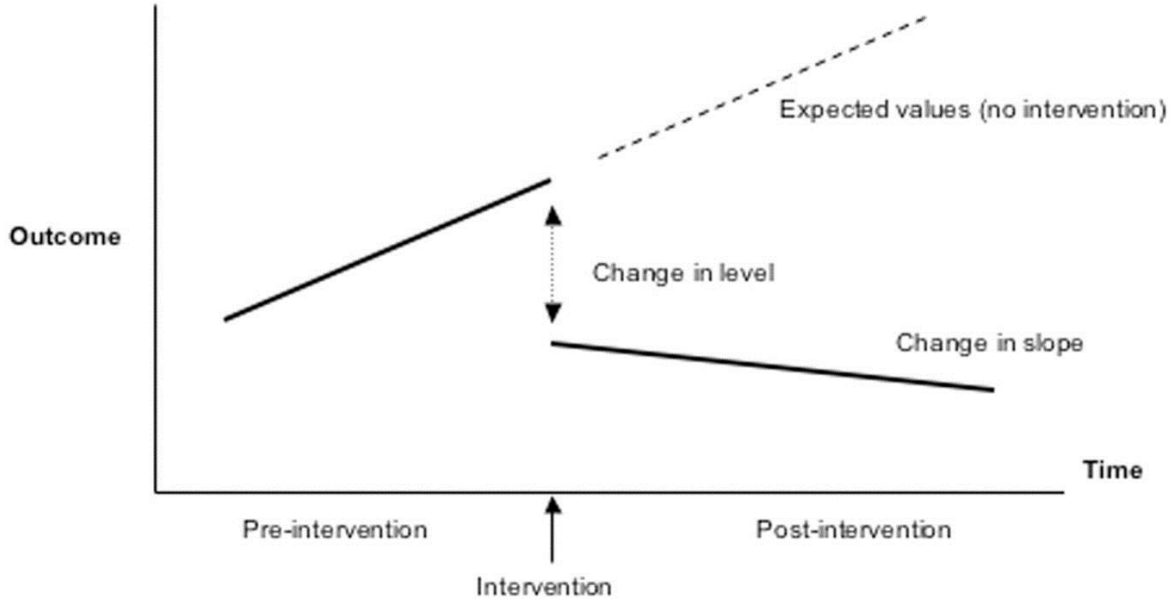
Quantitative Method Approach

A variety of quantitative analytic methods may be utilized by the independent evaluator to assess the BH demonstration in NYS Medicaid. Pre and post quasi-experimental design methods may include interrupted time series and difference in difference. Causal model designs will be applied in pre-design phases to develop comparable groups where applicable and feasible. Longitudinal mixed effect regression methods will be used to examine individual outcomes over time for the HARP population. Multiple analysis of variance and chi-square comparisons will be applied to compare population and acuity characteristics of the HARP qualified populations who are enrolled in HARPS, HIV SNPs and MMMC plans by NYC and ROS on an annual basis. Survey methods and qualitative methods will be used to collect consumer input on the demonstration. Data available within the New York Department of Health and Office of Mental Health as specified below will be utilized for these analyses. The specific outcomes, measures, data sources and hypotheses related to the above indicated questions are detailed in subsequent sections. Note that depending on the goal and question addressed, "enrolled" may mean enrolled in a Mainstream Medicaid Managed Care Plan which includes the Behavioral Health Carve-In, enrolled in a HARP Plan, or enrolled in a HARP plan and eligible for BH HCBS. The following are potential methodologies that may be used in the independent evaluation, but the independent evaluation may also use additional methodologies as needed.

Quantitative Method I – Interrupted Time Series

Evaluation Approach I will involve a pre/post analysis of "enrolled" members using an interrupted time series design. An interrupted time series design[1] is proposed to test hypotheses in assessing the BH demonstration and HARP's statewide impact. This is a quasi-experimental design in which summary measures of the outcome variable are taken at equal time intervals over a period prior to program implementation (independent variable), followed by a series of measurements at the same intervals over a period following program implementation, as shown in the idealized illustration in Figure 2.

Figure 2: Pre- and Post-Intervention Comparison of Outcome Variable using Interrupted Time Series Design.



This design allows for the primary objective of evaluating trends/trajectory of outcome metrics such as cost before and after program implementation. The methods used in this design allows for a clear display of the monthly outcome variable trend overtime, changes in outcome variable trajectory as well as the dependencies or correlations between consecutive monthly measurements.

As with any program implementation analysis, the primary challenge is defining and acquiring groups between which to compare individuals within and without the implementation demonstration i.e. Non-BH or Non-HARP as comparative groups for BH Mainstream and HARP enrolled individuals. This design was chosen in consideration of the fact that non-BH /non-HARP control groups are unlikely to be available, limiting the ability to separate the effects of the BH demonstration from other statewide health care reform initiatives that are ongoing such as DSRIP, the New York Prevention Agenda, the State Health Innovation Plan (SHIP) with the support of the State Innovation Models (SIM) grant, the Affordable Care Act, and other concurrent market forces. Given the limitation resulting from the likely absence of a comparison group, this design is advantageous in that potential confounders (i.e., other health care reform initiatives) are minimized in that they would have to occur contemporaneously with the introduction of the BH demonstration including HARPs in order to exert a confounding effect, which is unlikely, but is recognized as possible nonetheless. This design also has the advantage of accounting for secular trends in the outcome variables to which other non-BH

demonstration health reform initiatives would be expected to contribute.

To utilize the strength of this design, a segmented regression[2] will be used to analyze the interrupted time series data. This analysis enables the evaluation of changes in the level and trend in the outcome variable from pre- to post-intervention, and uses the estimates to test causal hypotheses about the intervention. In the post-intervention period, actual rates for the various metrics for each month will be compared to expected rates, while controlling for characteristics of the patients enrolled in the program, secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable. Analysis will be limited to patients with continuous Medicaid enrollment for the 12 months prior to the given intervention. Variables included in the regression adjustment will include factors such as prior inpatient, ED, and primary care utilization patterns (frequency), other resource use, diagnostic history, etc.

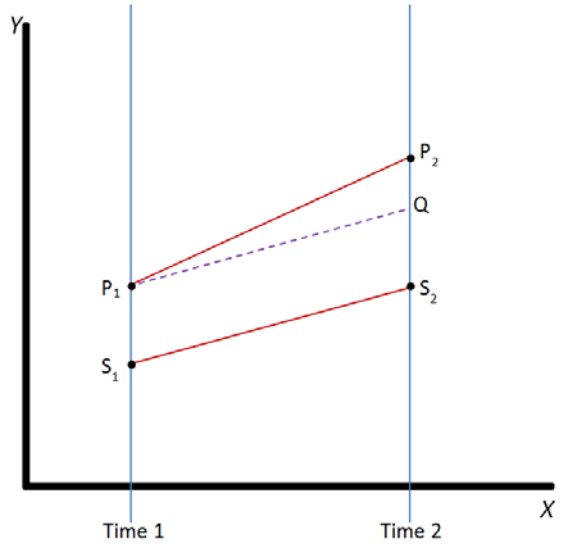
Quantitative Method II Difference in Difference Design (DD)

There is the potential to strengthen the above design with respect to causal inference by taking advantage of the phased in approach of the BH demonstration in which NYC implemented 6 months prior to the rest of state implementation. The use of the HARP eligible control group in ROS compared to NYC may be proposed by independent evaluator applicants, however, there are several issues to consider. First, the time lag between NYC and ROS is only 6 months. It is likely that in that first 6 months the system will still be going through many changes in order to be able to provide the new benefit package and to develop the new HARP product lines. It is unlikely that the 6 month time period will be sufficient to be able to identify changes between the two groups. In addition, the use of eligible control group in ROS compared to NYC may be a problem since changes in the health of patients in the ROS might be systematically different from NYC, due to, say, aid (socioeconomic), transportation and housing differences rather than the BH program implementation.

A more robust DD analysis will be performed (depending on data availability) by using eligible individuals who opt out of the HARP (HARP-Opt Out) as control for those who opt into HARP. This approach or strategy accounts for any secular trend/changes in the outcome metrics (it eliminates fixed differences not related to program implementation), with remaining significant differences attributable to the impact of program implementation[3] The study groups will be prepared by match-pairing individuals using propensity scores derived from logistic regression based on selected demographic, clinical and social indicators, and health care utilization characteristics (see Quantitative Method V).The outcome metrics, health care costs per member per month/year (PMPM/Y) and service use rates, such as hospital admit rates measured over two consecutive periods of two years before and two years after program implementation will be calculated (total duration of four years). Changes in outcome metrics from measurement period-1 (2013 – 2015), (2014 – 2016), to measurement period-2 (2016 – 2017), (2017 – 2018), will be compared for NYC and ROS respectively. Also,

changes in individuals who are HCBS eligible and opt for HCBS services will be compared to individuals who are HCBS eligible and do not opt for HCBS services using similar match-pairing and DD techniques.

Figure 3: Idealized representation of DD Method



Quantitative Method III Longitudinal Mixed Effect Regression Method

A Generalized Linear Mixed Model (GLMM) will be implemented to address the potential heterogeneity in the program/BH implementation effect and estimate an average program effect while controlling/adjusting for important covariates[4,5] The GLMM framework uses a model based approach to estimate HARP enrolled individual program effects allowing for program/BH implementation random effects.

This framework has the advantage of separating the effects of time from that of the BH implementation, accommodating the heterogeneity in the BH implementation effect, and accounting for serial correlations within individuals (resulting from repeated measurements). As with implementation longitudinal data, the outcome metrics such as employment, enrollment in formal education, social relationships, social strengths, and behavioral health service utilization may vary considerably over time due to a strong temporal trend before and/or after program implementation. Risk factors including homelessness, criminal justice involvement (arrest history, incarceration history), alcohol use, drug use, chronic physical health conditions, and traumatic life events would likely vary considerably over time. The GLMM framework helps determine the amount of variability that may be due to temporal trend and the amount due to the new program implementation. The GLMM was chosen because it accounts for the intrinsic differences

among individuals, the variability in program impact on individuals, and the potentially induced correlation by collecting data on the same individuals over time.

Quantitative Method IV Descriptive Statistics: Multiple Analysis of Variance and Chi-square Analysis

Comparisons will be made to examine characteristics of HARP enrollees in NYC and in the ROS in each annual period (10/2015-2020) using descriptive statistical methods for categorical, ordinal or continuous data. Chi-square analysis comparing NYC to ROS as independent samples will be performed for categorical outcome variables. McNemar's chi-square test will be performed to compare binary outcomes between correlated groups for each region before and after implementation. Similar analysis will be considered for comparing categorical outcome variables for each region year to year.

For continuous outcome variables, ANOVA will be used to test the difference in means score between independent samples from NYC and ROS. The use of repeated measures ANOVA for yearly changes within each region may be proposed by an independent evaluator, however, an important assumption of the repeated measure ANOVA known as sphericity may be violated. Correlations between data in year 1 and year 2 may not be the same as year 2 to year 3 and likewise between year 1 and year 3. This condition of equal correlations from one year to the other can be a problem given the continuous assignment, and enrollment into HARPs as well as the complexities surrounding the BH implementation. Paired t-test will be used to compare pairs of years and for multiple pair comparisons, say, for measurement of 3 years (comparing year 3 with year 2 and year 3 with year 1) a Bonferroni adjustment will be applied to the threshold p-value.

Quantitative Method V – Propensity Score Matching

Quantitative method V will involve using what is termed propensity or prognostic score matching to control for potential confounding by identifying a comparison group for specific study questions. This method may be used combined with Quantitative Method II to examine the impact of the HARP benefit on health outcomes and to examine the impact of HCBS services on recovery outcomes. A comparison group for the HARP benefit could be members qualified for HARP plans who opted out of the HARP and are enrolled in MMMC. A comparison group to examine HCBS services could be HARP members eligible for HCBS services but receiving only traditional services [6]. This method would be applied in the design phase with application for a variety of causal models which may be selected. Using prior utilization and diagnostic information, this approach attempts to identify recipients with similar characteristics during pre and post demonstration period. The method estimates each individual's conditional probability of being enrolled in HARPs (or HCBS for the assessment cohort). The propensity scores will be estimated using a

logistic regression, with the outcome being opting to enroll into HARPs (coded 1 = HARPS, 0 = HARP-Opt Out), opting to receive HCBS Services (coded 1 = HCBS, 0 = No HCBS), and predictors being derived from an array of demographic, clinical and social indicator constructs. The potential confounders will be selected a priori based on subject matter knowledge and in consultation with subject matter experts.

A greedy matching algorithm with an appropriate matching ratio of HARPs to HARP-Opt Out (1: n) will be used to create a matched analytic cohort based on the estimated propensity score and other appropriate service use indicator such as the number of psychiatric hospitalization days prior to program implementation[7]. Balance in covariate distribution between HARPs and HARP-Opt Out (or HCBS and No HCBS) in the matched analytic cohort will be assessed with weighted standardized difference[8]. The matched cohorts will be used for the quantitative methods indicated above where possible.

Quantitative Method VI – Exponential Smoothing Methods

An exponential smoothing method[17]will be used to examine the monthly, quarterly and yearly trends of service utilization or program enrollments, and cost of service use where appropriate. In this method, the trend/trajectory of a series of summary measurements of the outcome variable (rate of service use, program enrollments) taken at equal time intervals over a defined period are analyzed using smoothing techniques. Service use or program enrollment projections based on exponential smoothing techniques are weighted averages of past service use or enrollments, with the weights decaying exponentially as the outcome/observations get older. Thus, the more recent the outcome the larger the assigned weight. This allows for reliable examination of monthly, quarterly and yearly trends, as well as future projections of program enrollment or service use. This method allows for a clear display of the monthly service use and cost trend overtime, changes in service use and cost trajectory as well as the intrinsic nature (i.e. the dependence or correlations between consecutive months) of one monthly outcome to the other.

Consumer Survey Approach

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is administered on a bi-annual basis with Adults enrolled in all Medicaid Managed Care product lines according to the current quality strategy approved by CMS in the 1115 Waiver. Adult members with behavioral health needs are included in the CAHPS® survey, however, oversampling is not implemented to ensure that there is representation of members with behavioral health needs from mainstream product lines. The HARP MMC product lines will be will be included in the CAHPS® survey in 2018.

In addition, the HARP Perception of Care (HARP PCS) survey was developed by the State to evaluate HARP member perception of and experience with care. Members enrolled in HARPs and BH HCBS eligible members enrolled in HIV SNPs will be surveyed annually to measure experience with care, perception of care and perception of quality of life. This survey was derived from validated instruments intended to assess consumer perception of the performance of health plans and behavioral health services. Specifically, questions were drawn from the Experience of Care and Health Outcomes (ECHO) Survey, the Mental Health Statistics Improvement Program (MHSIP)/ OMH Consumer Assessment of Care Survey (CACS) Survey, the Personal Wellbeing Index adult version (PWI-A), and the Maryland Outcomes Measurement System. NYS OMH also formulated questions for pertinent topic areas where none could be found in existing instruments. The majority of questions address domains of member experience such as accessibility of services, quality of services, and appropriateness of care, wellness, quality of life, and social connectedness. Additionally, a set of socio-demographic questions are included which will allow examination of disparities. The current draft of the survey consists of 78 questions found in Appendix B.

The HARP PCS will be piloted by NYS OMH in the fall of 2016 with a small number of NYS OMH and OASAS programs. Final modifications to the HARP PCS will be completed based on pilot findings in the first quarter of 2017. The first HARP PCS will be implemented in Q4 of 2017.

The HARP PCS pilot will be implemented in 3-5 NYS OMH or OASAS funded programs in Q4 of 2016. Additional survey questions will be included to gather feedback from pilot participants about the length of the survey, clarity of the questions, and relevance of the questions. Surveys will be implemented by the State with the assistance of program administrators at selected programs and administered by non-direct care program staff at the pilot program sites. Participants will complete the surveys on site, with the option of mailing the survey back to OMH individually or in a sealed individual envelope with other respondents. Completed surveys will be processed and summarized by NYS OMH. NYS OMH will also collect survey response rate and administration feedback from program sites. The pilot findings will be used to finalize the HARP PCS instrument for full implementation in 2017.

Qualitative Method

Qualitative methods may include key informant interviews, focus groups, and surveys. Issues to be investigated qualitatively include notable program outcomes and challenges, effectiveness of governance structure and provider linkages, contractual and financial arrangements, changes in the delivery of patient care, the effect of other

ongoing health care initiatives (e.g., DSRIP, New York Prevention Agenda, Affordable Care Act) on the BH demonstration, HARP and HCBS services implementation and operation, and patient experience and satisfaction with services. The Independent Evaluator will develop key informant and focus group interviews to address the questions under each objective. Development will include the determination of interview questions with appropriate review and pre-testing to ensure that questions are comprehensive, understandable, and reliable.

The Independent Evaluator will determine a strategy for identifying a range of stake-holders to target for in-depth interviews and focus groups. At a minimum, stake-holders would be expected to include HARP enrollees; HARP Managed Care administrators; and HCBS service providers and would reflect variation in region (NYC vs ROS) and other contextual factors (e.g., urban vs rural). Managed Care Plans, providers and state agency offices would be used to facilitate contact and recruitment. Interviews and focus groups will be semi-structured such that questions to be asked will address consistent topics for a given category of respondent (e.g., administrator, provider, enrollee), while at the same time allowing for follow-up questions to probe for more in-depth responses. Modifications in the interview questions will be made as necessary based on responses obtained on early interviews.

Analysis will follow a framework described by Bradley, Curry, & Devers[9] that has been effectively used in health services research. Preliminary review of the data using a grounded theory approach (i.e. without predetermined categories) will be performed to identify emergent themes. A coding structure will then be established through an iterative process that labels concepts, relationships between concepts, and evaluative participant perspectives (i.e., statements that are positive, negative, or indifferent to their experiences or observations). The coding structure will also capture respondent characteristics (e.g., age, sex, position or role in organization) and setting (e.g., community based provider, HARP plan, MMC mainstream plan, NYS region). Responses will then be re-reviewed independently by at least two evaluation staff members, applying the finalized coding structure. Coding discrepancies between reviewers will be resolved through discussion to achieve consensus for the final coding of the data. Coded data will be analyzed and interpreted to identify major concept domains and themes.

Figure 2. Evaluation Tool for the New York State Behavioral Health Partnership Plan Demonstration Evaluation: October 1, 2015 through December 31, 2020

Goal 8: Improve Health and behavioral health outcomes for adults in Mainstream Medicaid Managed Care whose behavioral health care was previously carved out in

a fee for service payment arrangement

Evaluation Questions

1. To what extent are MMC enrollees accessing community based behavioral specialty services (see Appendix C for a list of specialty services), for example ACT, PROS, and first episode psychosis (FEP) programs?
2. To what extent are MMC enrollees accessing community based health care or integrated health/behavioral health care?

The quantitative methods to be used to investigate these two areas are discussed below. The outcomes, measures, data sources and hypotheses to be tested are shown in the Evaluation tool for Goal 8 (Table A) below.

Questions 1 and 2 will utilize a pre-post design with interrupted time series analysis (Quantitative Method I). The proportion of MMC enrollees using any and specific BH specialty services and average units used pre and post (2010-9/2015: 10/2015 to 2020) will be examined. A similar design will be used to examine the proportion of MMC enrollees receiving integrated care in primary care settings and average units used pre and post (2010-9/2015: 10/2015 to 2020). In addition, the percent of MMC enrollees with BH needs with no claims history for primary and preventive services in each annual period pre: post (2010-9/2015: 10/2015 to 2020) will be examined. Data from Medicaid claims will be utilized to examine all service patterns.

We expect that the use of BH specialty and integrated care services will be utilized by more individuals and that more units of service will be provided in the post intervention period compared to the pre period. We expect that the proportion of MMC enrollees with BH needs with no claims history for primary and preventive services in each annual period pre compared to the post period will decline.

The State recognizes complexity with respect to monitoring the utilization and uptake of treatment and services related to FEP and integrated primary care. Each topic is detailed below with respect to how evaluation questions related to services utilization may be approached by the State and Independent Evaluator.

<u>FEP Services</u>

The State provides evidence based treatment for FEP using the OnTrackNY (OTNY) Coordinated Specialty Care (CSC) program. This program provides treatment to individuals between the ages of 16 and 30 who have experienced non-affective psychosis for less than two years at the time of admission. Coordinated Specialty Care (CSC) is a multi-disciplinary team approach for delivering evidence-based services to young people experiencing first episode psychosis (FEP) with the goal of improving

outcomes by providing early intervention services[10]. OTNY evolved from the Recovery After an Initial Schizophrenia Episode (RAISE) Connection program, which was developed in partnership with the NYS OMH as part of the National Institute of Mental Health (NIMH)-funded RAISE Implementation and Evaluation Study (RAISE-IES). OTNY is considered to be an evidence based program model[11, 12]. The program currently has the capacity to serve 800 individuals per year across the state. Based on the incidence of schizophrenia (10 per 100,000) we expect to have 2000 new cases per year. Based on the current sample of patients served in OTNY we estimate that approximately 50% would be enrolled in Medicaid. It is notable that OTNY is a new program and will have limited enrollment prior to 2015. In addition, OTNY will be expanding across the state through the demonstration period.

It is notable that the current system for identification of FEP is driven primarily by provider referrals with MMMC plans assisting where possible. The State is working with MMMC plans on to develop a referral and tracking methodology for these enrollees with priority given to OTNY program enrollment. In addition, the State is still developing a system in which FEP individuals can become eligible for HARP enrollment in 2017. The State anticipates that over the course of the Demonstration period that identification, tracking and monitoring related to FEP will become more robust.

At the same time, the State is working to develop a Medicaid claims based algorithm which will be tested in collaboration with MMMC plans to develop capacity to identify incident cases of FEP using claims and potentially EHR data. This methodology is emergent at this time. It is anticipated that this method could be used to capture a measure of duration of untreated psychosis to validate the accuracy of first episode occurrence and to understand if providers and plans are improving timely access to treatment.

The State anticipates that over the course of the Demonstration period that the identification of incident cases of FEP will become more robust. Using this algorithm the State plans to identify Medicaid recipients meeting potential FEP criteria to examine the rate of identification of FEP in the MMC population over the 2015-2020 period and the duration of untreated psychosis. The Independent Evaluator will be able to take advantage of the methods and technologies developed over the demonstration for the external evaluation at the end of the Demonstration.

The OTNY data system provides a unique opportunity for the State and Independent Evaluator to identify the MMMC or HARP enrollees who are receiving OTNY services. Outcomes including rates of engagement, hospitalization and school and work participation are monitored via the OTNY data system. Outcomes related to Medicaid service utilization for emergency, inpatient, outpatient and HCBS services can also be

monitored. FEP utilization will be captured from the OTNY data system. The proportion of MMC enrollees receiving an evidence based treatment for first episode psychosis will be tracked using the OTNY data system.

We expect to see identification of FEP and utilization of the FEP programs to increase over the course of the demonstration. FEP is not currently a billable Medicaid service in NYS although NYS MMC plans are required to offer FEP as a plan benefit. It is anticipated that during the Demonstration period FEP will become a billable Medicaid service and utilization will be monitored using Medicaid claims in the future.

Integrated Behavioral Health Care

Provision of integrated behavioral health care programs is an integral part of the DSRIP Medicaid system re-design. Currently the State has 3 options for Behavioral Health Integration under DSRIP[13] (Goal 3ai). In the NYS implementation of DSRIP every PPS chose model 1 and some combination of the other two models, but there is not a minimum number of program sites operating selected models. As a result the level of penetration of the model within the PPS is not readily determined.

1. Model 1: Bringing BH services in to a PCMH or APC primary care practice. Performance provider systems work in partnership with behavioral health providers to offer behavioral health services on site. Providers implement a preventative screening (PHQ-9, SBIRT) to identify unmet behavioral health needs. If/when screenings are positive, provider refers patient to behavioral health provider for further evaluation and/or treatment.

2. Model 2: Bringing a Primary Care Provider to a BH clinic. Performance provider systems identify behavioral health service sites interested in providing primary care services on location. Provider then works with behavioral health provider to identify community needs, develop a structure for integration requirements and develop evidence-based standards of care.

3. Model 3: Implementing the IMPACT model (Collaborative Care) in a primary care practice. The IMPACT Model employs a collaborative team of professionals with complementary skills to fully integrate behavioral health treatment into primary care. This team includes a depression care manager, a primary care provider (PCP) and a consulting psychiatrist. The patient's PCP works with the care manager to develop and implement a stepped care treatment plan, and consults with the psychiatrist to change course of treatment for patients who do not improve after 10-

12 weeks. In over 80 randomized controlled studies, IMPACT has shown to improve PHQ-9 scores by >50% in 12 months.

The DSRIP metrics for integrated care are process metrics related to implementation of the elements of the chosen model. These process metrics rely on EHR and other reporting requirements specific to the State oversight of DSRIP. Population level outcomes would also be expected from having these services available to the Medicaid population. DSRIP outcomes such as reduction of ER utilization and hospital readmissions on a PPS level would be expected to improve over the course of the demonstration. At this time, the State does not have the ability to identify the receipt of integrated behavioral health care using Medicaid claims data. The State will examine how the DSRIP findings can be used by the Independent Evaluator to determine the penetration and impact of integration models on the MMMC population.

Table A: Evaluation tool for Goal 8

Q #	Outcome	Measure	Data Source	Related Hypotheses	Possible Methodologies
1	Improve access to behavioral health care specialty services (See Appendix C for specialty services)	Proportion of enrollees using any and specific BH specialty services and average units used pre and post (2010-9/2015: 10/2015 to 2020)	Medicaid Claims; OnTrack NY Client records	Utilization of BH specialty services will increase in the MMC population	Pre-post design with interrupted time series analysis
1	Improve identification of and access to care for First Episode Psychosis	Percent of MMC population identified as having first episode psychosis in	Medicaid Claims; OnTrack NY Client records	Identification of First episode psychosis will increase; utilization of evidence	Pre-post design with interrupted time series analysis

	patients	each annual period from baseline (2015 to 2020); Proportion of MMC population utilizing evidence based care for First Episode Psychosis in each annual period (2015 to 2020).		based care for first episode psychosis will increase; Duration of untreated psychosis will decrease	
2	Improve access to primary and preventive services	Percent of MMC BH population enrolled for entire prior 12 months with no claims history for primary and preventive services in each annual period pre: post (2010-9/2015: 10/2015 to 2020)	Medicaid Claims	Percent of MMC BH members without primary care utilization will decline	Pre-post design with interrupted time series analysis

Goal 9: Improve health, behavioral health and social functioning outcomes for adults in the HARP

The quantitative methods to be used to investigate the eleven questions related to this goal are discussed below. The outcomes, measures, data sources and hypotheses to be tested are shown in the Evaluation tool for Goal 9 (Table C) below. HARP refers to HARP enrollees in HARP or HIV SNP plans.

HARP enrollees

1. How has enrollment in HARP plans increased over the length of the demonstration?
2. What factors are associated with individuals choosing to opt out of HARP plans?
3. What are the demographic, social, functional and clinical characteristics of the HARP population? Are they changing over time?
4. What are the educational and employment characteristics of the HARP population? Are they changing over time?
5. To what extent are HARP enrollees accessing primary care?
6. To what extent are HARP enrollees accessing community based behavioral specialty services?
7. To what extent are HARP enrollees accessing community based health care or integrated health/behavioral health care?
8. To what extent is HARP quality of care improving, especially related to HEDIS®/QARR measures of health monitoring, prevention, and management of chronic health conditions?
9. To what extent are HARP enrollee experiences with care and access to health and behavioral health services positive?
10. To what extent are HARP enrollees satisfied with the cultural sensitivity of BH providers and their wellness, recovery, and degree of social connectedness?
11. To what extent are HARPs cost effective? What are the PMPM cost of inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox and emergency room services for the HARP population? Are these costs decreasing over time?

Evaluation Questions

Q1. How has enrollment in HARP plans increased over the length of the demonstration?

HARP plan enrollment will be assessed within the context of overall program enrollment. To assess the impact of HARP roll-out, the evaluation will examine how many HARP-eligible members are enrolled in each annual period in each MMC, HARP or HIV SNP. It is important to note that for this measure, there is no pre-implementation comparison or other group comparison possible. Quantitative Method

IV will be used to monitor year to year comparisons in NYC and in the ROS in each annual period for the period 10/2015 to 12/2020 and reported at the end of the demonstration period. It is expected that enrollment in HARP plans will increase over the length of the demonstration as new members are identified and original members opt to remain in the HARP or HIV SNP plans rather than joining a MMC mainstream plan. We expect that the majority of HARP eligibles will enroll in HARP or HIV SNP plans rather than in MMMC plans.

Medicaid enrollment data will be used for this analysis. Medicaid enrollment data are available lagged by one month. It should be noted that the first 9 months of the implementation include only NYC plans with the rest of NYS beginning 7/2016.

Q2. What factors are associated with individuals electing to or declining to enroll in HARP plans?

The demographic (age, gender, race, residential region), diagnostic (Dx) (MH Dx, SUD Dx, Dual Dx) and acute BH service utilization (BH inpatient (IP), SUD IP detox, SUD IP rehabilitation) characteristics of HARP-eligible members who are enrolled in each annual period in MMC, HARP or HIV SNPs will be compared (Quantitative Method IV). Demographic characteristics will be categorical, diagnostic characteristics dichotomous (y/n) and BH service utilization will be characterized as number of episodes in a year or number of days utilized for each service type per year. Comparisons will be made using chi-square analysis and Anova as appropriate according to data type (Quantitative Method IV).

We hypothesize that HARP eligible members who opt out may be younger and less behaviorally acute than those who remain enrolled in HARP/HIV SNP.

Medicaid enrollment and claims data will be used for this analysis. Medicaid enrollment data are lagged by one month. Medicaid claims data is lagged by 6-months. It should be noted that the first 9 months of the implementation include only NYC plans with the rest of NYS beginning 7/2016.

In addition, the qualitative reasons members have for opting back into MMMC is being collected by the State to assess reasons for opting out of the HARP. The data collected include a categorical list of reasons for declining and allow for open ended response by enrollees. The data are summarized on a weekly basis for NYC and ROS. The reasons for opting out will be monitored over time and cumulated by year 10/2015 to 12/2020. It is important to note that these data are not available on an individual member basis. Data are collected by the enrollment broker in the NY

Medicaid Choice Enrollment data system; however no recipient identifier is retained with the data.

3. **What are the demographic, social, functional and clinical characteristics of the HARP population? Are they changing over time?**
4. **What are the educational and employment characteristics of the HARP population? Are they changing over time?**

Questions 3 and 4 examine the detailed socio-demographic data which will be available for HARP enrollees in HARP and HIV-SNP plans via the BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment. These assessments are derived from the interRAI Community Mental Health Assessment®[14]. The BH HCBS Eligibility Brief Assessment is required annually for all HARP enrollees and HARP eligible HIV SNP enrollees. For screened individuals who meet BH HCBS eligibility criteria a BH HCBS Full Assessment is completed and repeated annually. As such, this detailed information will be available for HARP/HIV SNP members but are not available for HARP eligible members who opt out and return to MMC mainstream plans.

Two analytic approaches are recommended to be applied to these data to examine the above questions: population level year by year comparisons (Quantitative Method IV) and individual level analysis of change over time (Quantitative Method III). First, population characteristics will be examined in each annual period at the end of the demonstration (10/2015-2020) for HARP enrollees in HARP and HIV-SNP plans in NYC and ROS. Characteristics examined include socio-demographic, clinical, and recovery related measures including education, employment, social network, risk factors, home environment, social relationships, criminal justice involvement, top health diagnoses, behavioral diagnoses, behavioral health symptoms, substance related practices and behavioral health services accessed (Please refer to Appendix E for the BH HCBS Eligibility Brief Assessment and Appendix F for the BH HCBS Full Assessment used in the demonstration). These indicators will be coded as categorical, ordinal or continuous variables as appropriate for analysis. Comparisons using Quantitative Method IV include descriptive statistical methods (e.g., ANOVA, Chi-square) for categorical, ordinal or continuous data. It is expected that the distribution of the measured risk factors and protective factors for this population will shift toward fewer risk factors and greater protective factors. Regional (NYC vs ROS) differences in improvements may be observed. Specifically higher rates of educational and employment attainment will be observed among HARP enrollees over time as the program matures. Paired t-test will be used to compare pairs of years and for multiple pair comparisons, say, for measurement of 3 years (comparing year 3 with year 2 and year 3 with year 1) a Bonferroni adjustment will be applied to the threshold p-value.

Individual level change may be examined using longitudinal data analytic methods (Quantitative Method III). Individuals will have repeated BH HCBS Eligibility Brief Assessments and BH HCBS Full Assessments completed. Longitudinal change in risk and protective factors identified above will be examined to determine change trajectories using multivariable mixed effects regression methods (Quantitative Method III). Fixed effects will be identified including age, gender and race/ethnicity and time. Random effects will include risk and protective factor level at each annual time point.

It is important to note that for these questions, there is no pre-implementation comparison group available. The risk and protective, employment and education data collected via the BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment as part of this demonstration are not available prior to the demonstration so no pre-post comparison can be made. For some analyses, assessment data may be matched to enrollment and services data in the Medicaid data mart. Each assessment includes Medicaid Id so matching between the assessment data and Medicaid data will not be a barrier. In addition, since the HARP demonstration applies to ages 21-64 we do not anticipate the age structure of the eligible population to change. However, this will be examined to determine if changes in the population age structure may be impacting the analysis.

5. To what extent are HARP enrollees accessing primary care?

Pre-post approaches (Quantitative Method II) could be used to assess access to primary care among HARP eligible pre-implementation compared to HARP enrolled in HARP and HIV SNP plans post-implementation. The unit of analysis will be rate of primary or preventive care visits measured as members receiving one or more primary or preventive care visits in a year (e.g., the use of evaluation and management CPT codes or well visit codes by primary care physicians) from Medicaid claims data. We anticipate that HARP enrollees will access primary and preventive care at greater rates in comparison to HARP eligible populations prior to the demonstration. Changes in use of primary care and preventive care from measurement period-1 (2013 – 2015), (2014 -2016) to measurement period-2 (2016 – 2017), (2017 – 2018), and afterwards (2019-2020) will be compared for NYC and ROS respectively. Comparable members during the pre and post periods may be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method V). Medicaid claims will be utilized for these analyses.

6. To what extent are HARP enrollees accessing community based behavioral specialty services?

Pre-post approaches (Quantitative Methods I or/and II) could be used to assess access to community based behavioral specialty services (see Appendix C for list) among HARP eligible pre-implementation compared to HARP enrolled in HARP and HIV SNP plans post. The unit of analysis will be rates at which members use community based behavioral health specialty services in a month/quarter and within the year. This will be measured as the proportion of members receiving one or more community based behavioral health specialty service in each service category in a month/quarter and within the year. We anticipate that HARP enrollees will access community based behavioral health specialty services at greater rates in comparison to HARP eligible populations prior to the demonstration. Changes in use of behavioral health specialty services from measurement period-1 (2013 – 2015), (2014 -2016) to measurement period-2 (2016 – 2017), (2017 – 2018), (2019-2020) will be compared for NYC and ROS respectively. Analysis evaluating the monthly/quarterly utilization trends of community based behavioral health specialty services using Quantitative Method I may be limited to only HARP enrollees receiving HCBS services. Comparable members during the pre and post periods may be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method V). Analysis evaluating the changes in yearly utilization of community based behavioral health specialty services in the comparable matched cohort will be conducted using Quantitative Method II. Medicaid claims will be utilized for these analyses.

7. To what extent are HARP enrollees accessing Health Homes for care coordination?

Pre-post approaches (Quantitative Method I and II) could be used to assess access to Health Home care coordination among HARP eligible pre-implementation compared to HARP enrolled in HARP and HIV SNP plans post. The measure to be used will be the proportion of HARP enrollees engaged in health homes pre and post measurement period-1 (2013 – 2015), (2014 -2016) to measurement period-2 (2016 – 2017), (2017 – 2018) for NYC and ROS respectively, and subsequently (2019-2020). . We expect that access to care coordination services will increase in terms of health home engagement for HARP members.

Analysis evaluating the monthly/quarterly enrollments in health homes (utilization over time) will be conducted using Quantitative Method I. Analysis evaluating the changes in yearly utilization of health homes in the comparable matched cohort will be conducted using Quantitative Method II. Comparable members during the pre and post periods

maybe selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method V).
Medicaid claims will be utilized for these analyses.

8. **To what extent is HARP quality of care improving? (HEDIS®/QARR measures including health monitoring, prevention, chronic health conditions)**

Pre-post approaches (Quantitative Method II) will be used to assess improvements in quality of care related to health monitoring, prevention, chronic health and behavioral health among HARP eligible pre-implementation compared to HARP enrolled in HARP and HIV SNP plans. The measure specifications follow HEDIS® specifications for each measurement year.[15] Note that we expect HEDIS® quality of care metrics and value sets to change over the course of the demonstration period. The Independent evaluator will be expected to apply definitions as deemed appropriate. We expect that care quality will improve in the areas of behavioral health, cardiovascular disease, asthma and diabetes (Table B below). Changes in these measures from measurement period-1 (2013 – 2015), (2014 -2016) to measurement period-2 (2016 – 2017), (2017 – 2018), and afterwards (2019-2020) will be compared for NYC and ROS respectively. Comparable members during the pre and post periods will be selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method V). Metrics for these analyses are plan reported as part of the Medicaid quality oversight. These analyses may supplement plan submitted data with Medicaid claims data to enhance rates or may recalculate administratively derived HEDIS® metrics using Medicaid claims so that appropriate pre and post periods can be selected and to allow for identification of appropriate comparison groups.

Table B. Clinical Improvement Outcome Measures

Outcome	HEDIS® Measure Name	Source
Behavioral Health	Antidepressant Medication Management	Claims
	Diabetes Monitoring for People with Diabetes and Schizophrenia	Claims
	Diabetes Screening for People with Schizophrenia/BPD Using Antipsychotic	Claims

	Cardiovascular Monitoring for People with CVD and Schizophrenia	Claims
	Follow-up care for Children Prescribed ADHD Medication	Claims
	Follow-up after Hospitalization for Mental Illness	Claims
	Adherence to Antipsychotic Medications for People with Schizophrenia	Claims
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Claims
	Follow-up After Emergency Department Visit for Mental Illness (FUM)	Claims
	Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	Claims
Diabetes	Comprehensive Diabetes Care	Claims
Cardiovascular	Controlling high blood pressure (CBP)	Plan submitted
Asthma	Medication Management for People with Asthma	Claims

9.To what extent are HARP enrollees experiences with care and access to health and behavioral health services positive?
10.To what extent are HARP enrollees satisfied with the cultural sensitivity of BH providers, and their wellness, recovery, and degree of social connectedness?

Question 9 will utilize the Health Plan version of the CAHPS® survey to examine HARP enrollee experience with care and perception of access to health and behavioral health services. We expect that HARP enrollee experience with care and perceived access to health and behavioral health services will improve over time. Quantitative method IV will be used to examine year to year comparisons of the survey responses by NYC and ROS.

The CAHPS® survey will be administered to adults via the EQRO contract in 2017 and 2019. The survey administration will include a random sample of individuals in HARPs. The survey is administered by both mail and telephone, and assesses patients' experiences with health care providers and health plan staff. This includes information on patient experience with access to care, experiences with health care providers and health plan support. Questions specific to behavioral health include: need for mental health or SUD treatment, access to mental health or SUD treatment, satisfaction with mental health or SUD treatment, and self-rating of overall mental health.
Given confidentiality agreements, only de-identified CAHPS® data will be available for use. This limits the ability to make pre-post comparisons. In addition, the survey will not be oversampled in terms of mainstream populations with mental health issues or HARP eligible enrollees in HIV SNP plans. This limitation also applies to current CAHPS® results. Since the BH population is not oversampled it is not possible to examine what the existing reporting patterns are for this sub-population.

Question 10 will utilize the HARP Perception of Care Survey (PCS) (See Appendix B). We expect that HARP enrollee satisfaction with the cultural sensitivity of their behavioral health providers will increase over the length of the demonstration. We also expect that HARP enrollee satisfaction with their wellness, recovery, and degree of social connectedness will improve over the time of the demonstration. Quantitative method IV will be used to examine year to year comparisons of the survey responses by NYC and ROS.

The PCS was developed by NYS with advocate, program and psychiatric research input. The PCS is derived from a number of standardized instruments including: the Experience of Care and Health Outcomes (ECHO) Survey, the Mental Health

Statistics Improvement Program (MHSIP) Survey, the Personal Wellbeing Index adult version (PWI-A), and the Maryland Outcomes Measurement System. NYS OMH also formulated questions for pertinent topic areas where none could be found in existing instruments. The PCS is designed to collect experience with behavioral health care in terms of access and perception of quality of life in the areas of health, wellness and social functioning. The PCS will be piloted by NYS in 2016 and will be collected annually on a random sample of HARP members in HARP and HIV-SNP plans starting 2017 through 2020. The annual implementation will be via the EQRO contract.

Since this is a new survey, the State will pilot the instrument and obtain consumer feedback in the fall of 2016. The 2016 pilot will be conducted by NYS OMH and OASAS program staff and will occur in BH specialty program settings including ACT, PROS and OASAS outpatient rehabilitation programs. Medicaid eligible consumers in these settings are expected to be HARP enrolled. Agency consumer affairs liaisons will assist program staff with the survey implementation and to obtain consumer feedback. It is expected that changes will be made to the survey based on the pilot.

HARP members enrolled in HARP or HIV-SNP plans will be surveyed annually starting in 2017. The survey will be implemented by the EQRO using a random sampling methodology of HARP enrollees by product line for HARPs and HIV SNPs. Methods to improve response rate from this representative sample will include reminder calls and mailing.

Measures will be derived at the domain and item levels. Specific survey domains include Perception of Outcomes, Access and Quality of Care, Appropriateness of Services, Social Connectedness, Wellness, and Quality of Life. Demographics are also collected on the form to monitor disparities. Items that will be measured include member's perception of BH provider's responsiveness to their cultural background, a seven item scale measuring satisfaction with quality of life, presence of social support, relationships, and beliefs about health and wellness. In terms of specific measurement methods, satisfaction with quality of life will be measured on a scale from 0 to 10, social connectedness items will be measured on a five item Likert agreement scale, and beliefs about health and wellness will be measured on a four item Likert frequency scale. A draft of the full survey can be found in Appendix B. Data from this survey will allow the State and plans to monitor HARP members' perception of services and how their behavioral health services affect different areas of their life. Findings will be examined for change in BH services satisfaction levels over time. Surveys will be identified to allow for linking responses to Medicaid claims and other administrative data.

We expect that survey responses will be consistently high and improving over the

demonstration time frame. Pre and post comparisons will not be possible given that the PCS survey will be implemented in the 2017-2020 periods with no pre demonstration data collection.

11. Costs: To what extent are HARPs cost effective? What are the PMPM cost of acute BH services (e.g. inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox and emergency room services) for the HARP population? Are these costs decreasing over time?

Pre-post approaches (Quantitative Methods I and II) are recommended to be applied to these data to examine the trends and potential changes in costs for care for HARP-eligible members following the implementation of the program. This global assessment could examine whether shifting costs in any of the named service types above are offset elsewhere in the continuum of care (and even where). We expect that costs for HARP enrollees are shifting from acute services to non-acute outpatient based health and behavioral health services. To assess the potential/expected shifts in cost over time, two separate trend analyses using Quantitative Method I may be conducted to 1) evaluate the PMPM cost trend of acute BH services 2) evaluate the PMPM costs trend of non-acute outpatient services for HARP enrollees pre and post program implementation. In addition, changes in mean annual PMPM cost acute BH services and non-acute outpatient services in the comparable matched cohort will be conducted using Quantitative Method II.

The analyses, PMPM cost of acute and non-acute services as described above will be conducted using data from measurement period-1 (2013 – 2015), (2014 -2016) to measurement period-2 (2016 – 2017), (2017 – 2018), and afterwards through (2019-2020), for NYC and ROS respectively. Comparable members during the pre and post periods maybe selected using the HARP population algorithm and propensity score matching techniques (Quantitative Method V). Medicaid claims will be utilized for these analyses.

Table C: Evaluation tool for Goal 9

Q #	Outcome	Measure	Data Source	Related Hypotheses	Possible Methods
1	Increase HARP Enrollment	HARP eligible members who in each annual period are in MMC, HARP or HIV SNP	Medicaid Enrollment	HARP enrollment will increase & the majority of HARP eligibles will enroll in HARP or HIV SNP plans rather	Year to year comparisons in NYC and in the ROS in each annual period for the

		(10/2015 -2020)		than MMC mainstream plans	period 10/2015 to 12/2020 and reported at the end of the demonstration period (Quantitative Method IV)
2	Describe characteristics of members electing to or declining enrollment in HARP & Reasons for declining enrollment in HARP	Group differences in demographic (age, race, gender), BH service utilization, and diagnostic characteristics of the HARP eligible enrolled members in HARP/HIV-SNP and HARP eligible who opt out for MMMC in each annual period (10/2015-2020). The qualitative reasons for opting out of HARP will be monitored over time and cumulated by year 10/2015 to 12/2020.	Medicaid Claims; Medicaid Choice enrollment data	HARP eligible members who opt out are younger and less behaviorally acute than those who remain enrolled in HARP/HIV SNP	Demographic characteristics, BH service utilization, diagnosis on a year to year basis during the demonstration period. Comparisons will be made using chi-square analysis and Anova as appropriate according to data type (Quantitative Method IV).
3	Compare	Year to year	Medicaid	On a population	Two analytic

	demographic, social, functional and clinical characteristics of the HARP enrolled population and demographics characteristics of the HARP enrolled compared to HARP eligible population	comparison (baseline 10/2015-12/2020) of HARP enrollees in terms of social, functional and clinical characteristics in each annual period (10/2015-12/2020) language, risk factors, home environment, social relationships, criminal justice involvement, top health diagnoses, behavioral diagnoses, behavioral health symptoms, substance related practices and behavioral health services accessed. Measures that will be tracked in each annual period are: Percent of HARP enrollees by the following socio-demographic characteristics: age, sex, gender identity, race, ethnicity, preferred language, marital status, education, and sexual orientation Percent of HARP enrollees with the following risk factors: homelessness, criminal justice involvement (arrest history, incarceration history), alcohol use, drug use, chronic	claims BH HCBS Eligibility Brief Assessment BH HCBS Full Assessment	level, it is expected that the distribution of the measured risk factors and protective factors for this population will shift toward fewer risk factors and greater protective factors over time as the program matures; Regional (NYC vs ROS) differences in improvements may be observed. On an individual level, trajectories of improvement in risk and protective factors over time will be observed.	approaches are recommended to be applied to these data to examine the above questions: population level year by year comparisons (Quantitative Method IV) and individual level analysis of change over time using Quantitative Method III Generalized Linear Mixed Models (GLMM) will be implemented to address the potential heterogeneity in the program/BH implementation effect and estimate an average program effect while controlling/adjusting for important covariates

		physical health conditions, and traumatic life events Percent of HARP enrollees with the following protective factors: employment, enrollment in formal education, social relationships, social strengths, and behavioral health service utilization			
4	Improve educational and employment characteristics of the HARP population	Year to year comparison (baseline 10/2015-12/2020) of average HARP beneficiary scores on employment status, employment arrangement, employment compensation, employment supports, enrollment in formal education, and education supports. Measures that will be tracked are: Employment 1. The percentage of members currently employed 2. The percentage of members currently competitively employed 3. The percentage of members employed at least 35 hours per week in the past month	Medicaid claims BH HCBS Eligibility Brief Assessment BH HCBS Full Assessment	Higher rates of educational and employment attainment will be observed for the HARP enrolled population over time as the program matures; Individual level improvements will be noted	Two analytic approaches are recommended to be applied to these data to examine the above questions: population level year by year comparisons (Quantitative Method IV) and individual level analysis of change over time using Quantitative Method III Generalized Linear Mixed Model (GLMM) will be implemented to address the potential

		4. The percentage of members employed at or above the minimum wage 5. The percentage of members who prefer change in their employment situation 6. The percentage of members who prefer change in employment supports Education 7. The percentage of members currently enrolled in a formal education program 8. The percentage of members who prefer change in their level of education 9. The percentage of members who prefer a change in educational support services			heterogeneity in the program/BH implementation effect and estimate an average program effect while controlling/adjusting for important covariates
5	Improve access to primary and preventive services	Percent of HARP – eligible members in pre period compared with HARP enrolled members in post period with no claims history for primary and preventive services pre and post measurement period-1 (2013 – 2015) to measurement period-2 (2016 – 2017), (2017 –	Medicaid Claims	Percent of HARP members without primary care access will decline	Quantitative Method II Pre-post design with Difference in difference analysis Quantitative

		2018), (2019-2020)			Method II; Quantitative Method V.
6	Improve access to behavioral health care specialty services (See Appendix C for specialty services)	Proportion of HARP enrollees using any and specific BH specialty services pre and post measurement period-1 (2013 – 2015) to measurement period-2 (2016 – 2017), (2017 – 2018), (2019-2020)	Medicaid Claims;	Access to and Utilization of BH specialty services will increase	Quantitative method I Pre-post design with interrupted time series analysis; Quantitative Method II; Quantitative Method V.
7	Increase access to care coordination (health homes)	Proportion of HARP enrollees engaged in health homes pre and post measurement period-1 (2013 – 2015) to measurement period-2 (2016 – 2017), (2017 – 2018), (2019-2020)	Medicaid Claims	Access to care coordination services will increase in terms of health home engagement for HARP members	Quantitative method I Pre-post design with interrupted time series analysis; Quantitative Method II; Quantitative Method V.
8	Improve quality of care related to health monitoring, prevention, chronic health and behavioral health (Refer to Table B)	HEDIS®/QARR rates for HARP plans measurement period-1 (2013 – 2015) to measurement period-2 (2016 – 2017), (2017 – 2018), (2019-2020)	HEDIS®/QARR Medicaid Claims	HEDIS®/QARR quality profiles for HARP plans will improve over time as the program matures	Comparable members during the pre and post periods will be selected using the HARP population algorithm and propensity score

					matching techniques (Quantitative Method V).Quantitative method II Pre-post design with using DID analysis
9 & 10	Improve HARP enrollees self-reported experience of care related to access, health, behavioral health and HCBS services; Improve HARP enrollees satisfaction with care in terms of wellness and recovery, social connectedness and cultural sensitivity of services.	Percent of HARP enrollees that were satisfied with access to care, communication and knowledge of Medicaid managed care in each annual period (2017-2020) Measures derived from the CAHPS® survey that will be tracked in 2017 and 2019 are: Percentage of HARP enrollees who report that was easy to get mental health treatment Percentage of HARP enrollees who report that was easy to get SUD	CAHPS® Survey HARP Perception of Care Survey	Perception of experience of care and satisfaction with care will improve over time as the program matures. HARP enrollee satisfaction with the cultural sensitivity of their behavioral health providers will increase over the length of the demonstration. HARP enrollee satisfaction with their wellness, recovery, and degree of social connectedness will improve over the time of the demonstration.	Quantitative Method IV Year to year comparisons in NYC and in the ROS in each annual period for the period 10/2015 to 12/2020 and reported at the end of the demonstration period

		treatment Percentage of HARP enrollees who rated their mental health treatment positively Percentage of HARP enrollees who rated their SUD treatment positively Percentage of HARP enrollees who rated items related to communication with health care providers positively Measures that will be derived from the PCS are: Percentage of HARP members who report that their behavioral health care was responsive to their cultural background in each annual period (2017-2020)			

		Percent of HARP members who had a positive overall rating of quality of life in each annual period (2017-2020). Percent of HARP members who had overall positive beliefs about health and wellness in each annual period (2017-2020) Percent of HARP members who rated PCS survey questions in the social connectedness domain positively in each annual period (2017-2020).			
11	Decrease PMPM cost of inpatient psychiatric services, SUD ancillary withdrawal, hospital-based detox and emergency room services for the HARP	PMPM cost of acute and non-acute services will be conducted using data from measurement period-1 (2013 – 2015) to measurement period-2 (2016	Medicaid claims	We expect that costs for HARP enrollees are shifting from acute services to non-acute outpatient based health and behavioral health services.	Analytic Method I Pre-post design with interrupted time series analysis; Quantitative Method II

	population	– 2017), (2017 – 2018), (2019-2020), for NYC and ROS respectively.			

Goal 10: Develop Home and Community Based services focused on recovery, social functioning, and community integration for individuals in HARPs meeting eligibility criteria

The quantitative methods to be used to investigate the four questions related to this goal are discussed below. The outcomes, measures, data sources and hypotheses to be tested are shown in the Evaluation tool for Goal 10 (Table E) below. HARP refers to HARP enrollees in HARP or HIV SNP plans.

Evaluation Questions

1. **Access to Care: To what extent are HARP enrollees deemed eligible to receive Home and Community Based Services (HCBS)?**

Question 1 focuses on examining the HCBS eligibility determinations for HARP members and HARP eligible HIV-SNP members. All HARP and HARP eligible HIV-SNP members will be assessed for HCBS eligibility using the BH HCBS Eligibility Brief Assessment. The BH HCBS Eligibility Brief Assessment is used to identify individuals who may have functional needs and service/support needs that could be addressed by HCBS services. HCBS services are divided into two tiers. Eligibility for Tier 1 services will include a lower threshold for needs than Tier 2 services. Tier I includes peer, employment and/or education supports. Tier 2 includes all Tier 1 BH HCBS services plus additional services as specified in Table D to individuals whose medical need surpasses the need for Tier 1 services. Crisis respite HCBS services are available to all HARP enrollees, regardless of the tier under which they receive services. This includes intensive crisis respite or short term crisis respite in a dedicated facility. Individuals determined to be HCBS eligible receive a comprehensive assessment using the BH HCBS Full Assessment tool. The BH HCBS Full Assessment is used to develop a client-centered plan of care for the individual. Behavioral Health Home and Community Based Services were offered beginning in January 2016 in NYC and in October 2016 for ROS.

We expect that 75% of HARP members will be eligible for any HCBS services, 75% of HARP members will be eligible for HCBS Tier 1 services and 70% of HARP members will be eligible for HCBS Tier 2 services. We expect these targets

to be achieved by the end of the demonstration. Comparisons will be made to examine characteristics of HARP enrollees deemed eligible in NYC and in the ROS in each annual period (10/2015-2020), and from year to year using descriptive statistical methods for categorical, ordinal or continuous data (Quantitative Method IV). Data from the BH HCBS Eligibility Brief Assessment (demographic, clinical) and from Medicaid claims (plan membership, HCBS eligibility status) will be utilized for these analyses.

It is important to note that for this measure, there is no pre-implementation comparison possible. For Goal 10 Questions 1 and 2 we expect that as the HARP program matures, it would be possible to compare those members eligible for HCBS and those receiving HCBS to those deemed ineligible or eligible but not accessing services. These comparisons could examine any significant differences in term of population demographic characteristics (e.g. age, gender, residential region), plan membership (HARP Plan) and clinical characteristics (e.g, MH Dx, SUD Dx, Dual Dx).

Table D: Behavioral Health HCBS
BH HCBS Assessment • BH HCBS Eligibility Brief Assessment • BH HCBS Full Assessment
Rehabilitation • Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST)
Empowerment Services-Peer Supports
Habilitation Services
Respite • Short-term Crisis Respite • Intensive Crisis Respite
Non-medical transportation
Family Support and Training
Employment Supports • Pre-vocational • Transitional Employment • Intensive Supported Employment • On-going Supported Employment
Education Support Services

2. **To what extent are HARP enrollees who are deemed eligible receiving Home and Community Based Services?**

The expectation is that the monthly, and annual utilization of HCBS services will increase over the demonstration period. We expect that 75% of HARP members deemed eligible for HCBS services will utilize these services. The monthly and annual rate of utilization of BH HCBS will be examined using (Quantitative Method VI). The unit of analysis will be rates at which HARP enrollees deemed eligible use BH HCBS services in a month and within the year. This will be measured as the proportion of HARP enrollees receiving one or more BH HCBS service in each tier in a month and within the year. Rates will be examined monthly and annually at the statewide, regional and HARP plan levels over the period 2016-2020. Also, average annual percent change in program enrollments or service use or both will be assessed at the statewide, regional levels from year to year starting from 2016 and thereafter. The average annual percent change for the year of assessment will be calculated as the difference in average service use between that year and the prior year divided by the average of the prior year. Data from the BH HCBS Eligibility Brief Assessment (demographic, clinical) and from Medicaid claims (plan membership, HCBS eligibility status) will be utilized for these analyses. Additionally, GLMM (Quantitative Method III) will be used to examine the association between BH HCBS service utilization for those deemed eligible (used versus not, used 6 or more months versus less) controlling for demographic and clinical characteristics, and time.

It is important to note that for this measure, there is no pre-implementation comparison possible. For Question 1 and question 2 we expect that as the HARP program matures, it would be possible to compare those members eligible for HCBS and those receiving HCBS to those deemed ineligible or eligible but not accessing services. These comparisons could examine any significant differences in term of population demographic characteristics (e.g. age, gender, residential region), plan membership (HARP Plan) and clinical characteristics (e.g, MH Dx, SUD Dx, Dual Dx).

3. **To what extent has the demonstration developed provider network capacity to provide behavioral health Home and Community Based Services for HARPs?**

This question addresses the need for network adequacy to provide HCBS services. It is important to note that for this measure, there is no pre-implementation comparison possible, but as the HARP program matures, it would be possible to monitor rates of

provider participation in HARPs / HIV SNPs and the rate of providers per member population.

The extent to which HCBS service providers are available and contracted with by MMC HARP/HIV SNP plans will be examined. The measures include the number of providers contracted for BH HCBS in MMC HARP plans and the Ratio of BH HCBS providers per 1,000 enrollees. Year to year comparisons for the period 2016-2020 at the statewide, NYC, and ROS, county and HARP plan levels will be conducted (Quantitative Method IV). The Medicaid Managed Care HCBS Provider Network Data System will be used to determine HCBS provider information related to geographic areas served and plan contracts. Medicaid claims will be used to determine HARP enrollment.

A year to year comparison of the number of complaints related to access to HCBS services will be done. Collection of complaints related to HCBS is done through a designated email address which has been available to New York State OMH Providers since October 2015. OMH has designated staff to monitor and manage the mailbox. Designated staff has created an extended tracking system that includes multiple fields. These fields include origin of inquiry, type of inquiry, Primary and Secondary topics, fields for each MCO to indicate if they are part of the inquiry, which NYS region the inquirer is located in, name of the inquirer, and if forwarded to other state agencies. Through this data collection, issues related to HCBS are identified, monitored and remedied.

Monitoring of complaints is coordinated with the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and the New York State Department of Health (DOH). The three agencies meet regularly to identify trends, urgent issues and outstanding emails. NYS OMH is able to generate complaint reports from a linked database. These reports can be created via subject matter, if routed to DOH/OASAS, type of inquiry (complaint, question) and date opened/completed.

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4. Does targeting of BH HCBS more narrowly lead to increased numbers of members without access to appropriate BH care? (What are the consequences of targeting availability of BH HCBS to a more narrowly defined population than the criteria in the State Plan?)

The State will examine how total costs PMPM have increased or decreased following the implementation of HARP and for HARP enrollees with and without BH HCBS access through HARPs using Quantitative Methods I and II. The state will recommend a pre-

post design that examines the potential changes in costs for care for HARP-eligible members following the implementation of the program.

We expect that the added costs arising from access to BH HCBS are offset elsewhere in the continuum of care. For example, we expect that costs and utilization of employment, education or peer services will offset hospital costs and utilization over the course of the demonstration.

The outcome metrics, health care costs per member per month/year (PMPM/Y) and service use rates, such as hospital admit rates measured over two consecutive periods of two years before and two years after program implementation will be calculated (total duration of four years). Changes in outcome metrics from measurement period-1 (2013 – 2015), (2014 – 2016), to measurement period-2 (2016 – 2017), (2017 – 2018), will be compared for NYC and ROS respectively. Also, changes in individuals who are HCBS eligible and opt for HCBS services will be compared to individuals who are HCBS eligible and do not opt for HCBS services using similar match-pairing and DD techniques. Specific HCBS service types will also be tested. Changes in individuals who are Tier 1 HCBS eligible and opt for Tier 1 HCBS services will be compared to individuals who are Tier 1 HCBS eligible and do not opt for Tier 1 HCBS services using similar match-pairing and DD techniques. Additionally, changes in individuals who are Tier 2 HCBS eligible and opt for Tier 2 HCBS services will be compared to individuals who are Tier 2 HCBS eligible and do not opt for HCBS services using similar match-pairing and DD techniques

Table E: Evaluation tool for Goal 10

Q #	Outcome	Measure	Data Source	Related Hypotheses	Possible Methods

1	Access to Care: To what extent are HARP enrollees deemed eligible to receive Home and Community Based Services?	Year to year comparison of statewide, NYC, and ROS rates of percentages of HARP enrollees deemed eligible for any and for specific HCBS services	BH HCBS Eligibility Brief Assessment BH HCBS Full Assessment Medicaid Claims	We expect that 75% of HARP members will be eligible for any HCBS services, 75% of HARP members will be eligible for HCBS Tier 1 services and 70% of HARP members will be eligible for HCBS Tier 2 services by the end of the demonstration	Comparisons will be made to examine characteristics of HARP enrollees deemed eligible in NYC and in the ROS in each annual period (10/2015-2020), and from year to year using descriptive statistical methods for categorical, ordinal or continuous data (Quantitative Method IV).
2	Access to Care: To what extent are HARP enrollees who are deemed eligible receiving Home and Community Based Services?	The monthly and annual rate of utilization of BH HCBS will be examined at the statewide, regional and HARP plan levels over the period 2016-2020. Data from the BH HCBS Eligibility Brief Assessment (demographic, clinical) and from Medicaid claims (plan membership, HCBS eligibility status) will be utilized for these analyses to examine	Medicaid Claims BH HCBS Eligibility Brief Assessment	We expect PMPM BH HCBS utilization to increase over the course of the demonstration.	Monthly and Yearly rate of utilization of BH HCBS will be examined using Quantitative Method VI and Generalized Linear Mixed Model (GLMM, Quantitative Method III) used to address the potential heterogeneity in BH HCBS service use and estimate an average program effect while controlling/adjusting for important covariates Rates will be examined at the statewide, regional and HARP plan levels over the period 2016-2020

3	To what extent has the demonstration developed provider network capacity to provide behavioral health Home and Community Based Services for HARPs?	Year to year comparison of statewide, NYC, and ROS rates of behavioral health home and community based provider participation in Medicaid managed care plans by county; ratio of BH HCBS providers per 1,000 enrollees; Examine complaints and appeals to determine if plans, providers or members have requested BH HCBS but were	BH HCBS Eligibility Brief Assessment BH HCBS Full Assessment Medicaid Claims Complaints and appeals submitted to the State Medicaid Managed Care HCBS Provider Network Data System	We expect the number and ratio of BH HCBS providers per 1,000 enrollees to increase over the course of the demonstration	Year to year comparisons for the period 2016-2020 at the statewide, NYC, and ROS, county and HARP plan levels will be conducted (Quantitative Method IV).
4	Access to care: What are the consequences of targeting availability of BH HCBS to a more narrowly defined population than the criteria in the State Plan? What are the PMPM costs of BH HCBS for HARP enrollees	Outcome metrics, health care costs per member per month/year (PMPM/Y) and service use rates, will be calculated (total duration of four years). Changes in outcome metrics from measurement period-1 (2013 – 2015), (2014 – 2016), to measurement period-2 (2016 – 2017), (2017 – 2018), will be compared for NYC and ROS respectively. Also,	Medicaid Claims BH HCBS Eligibility Brief Assessment BH HCBS Full Assessment	We expect that the added costs arising from access to BH HCBS will be offset elsewhere in the continuum of care.	Quantitative Methods 1 and 2: The State recommends a pre-post design that examines the potential changes in costs for care for HARP-eligible members following the implementation of the program. The outcome metrics, health care costs per member per month/year (PMPM/Y) and service use rates, such as hospital admit rates measured over two consecutive periods of two years before and two years after program implementation will be calculated (total duration of four years). Changes in outcome metrics from measurement period-1 (2013 – 2015), (2014 –

	who receive services?	changes in individuals who are HCBS eligible and opt for HCBS services will be compared to individuals who are HCBS eligible and do not opt for HCBS services using similar match-pairing and DD techniques.			2016), to measurement period-2 (2016 – 2017), (2017 – 2018), will be compared for NYC and ROS respectively. Also, changes in individuals who are HCBS eligible and opt for HCBS services will be compared to individuals who are HCBS eligible and do not opt for HCBS services using similar match-pairing and DD techniques.

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Appendix A
HARP Targeting Criteria and Risk Factors[16]

A. **HARPs:** Adult Medicaid beneficiaries 21 and over who are eligible for mainstream MCOs are eligible for enrollment in the HARP if they meet either:
   i. Target criteria and risk factors as defined below (Individuals meeting these criteria will be identified through quarterly Medicaid data reviews by Plans and/or NY State); or
   ii. Service system or service provider identification of individuals presenting with serious functional deficits as determined by:
      a. A case review of individual's usage history to determine if Target Criteria and Risk Factors are met; or
      b. Completion of HARP eligibility screen.

B. ***HARP Target Criteria:*** The State of New York has chosen to define HARP targeting criteria as:
   i. Medicaid enrolled individuals 21 and over;
   ii. SMI/SUD diagnoses;
   iii. Eligible to be enrolled in Mainstream MCOs;
   iv. Not Medicaid/Medicare enrolled ("duals");
   v. Not participating or enrolled in a program with the Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).

C. ***HARP Risk Factors***: For individuals meeting the targeting criteria, the HARP Risk Factor criteria include any of the following:
   i. Supplemental Security Income (SSI) individuals who received an "organized"[1] MH service in the year prior to enrollment.
   ii. Non-SSI individuals with three or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
   iii. SSI and non-SSI individuals with more than 30 days of psychiatric inpatient services in the three years prior to enrollment.
   iv. SSI and non-SSI individuals with 3 or more psychiatric inpatient admissions in the three years prior to enrollment.
   v. SSI and non-SSI individuals discharged from an OMH Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.
   vi. SSI and non-SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five years prior to enrollment.
   vii. SSI and non-SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health treatment in the four years prior to

enrollment.

viii. Residents in OMH funded housing for persons with serious mental illness in any of the three years prior to enrollment.

ix. Members with two or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.

x. Members with one inpatient stay with a SUD primary diagnosis within the year prior to enrollment.

xi. Members with two or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD related medical diagnosis-related group and a secondary diagnosis of SUD within the year prior to enrollment.

xii. Members with two or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.

xiii. Individuals transitioning with a history of involvement in children's services (e.g., RTF, HCBS, B2H waiver, RSSY).

D. **Behavioral Health Home and Community Based Services (BH HCBS) Service Eligibility and Assessment Process:** HARP members who meet Targeting Criteria and Risk Factors as well as Need-Based Criteria (below), will have access to an enhanced benefit package of BH HCBS.

i. **Need-based Criteria**: Individuals meeting one of the Needs-Based Criteria identified below will be eligible for BH Home and Community Based Services:

   a. An individual with at least "moderate" levels of need as indicated by a State designated score on a tool derived from the interRAI Assessment Suite.

   b. An individual with need for BH HCBS services as indicated by a face to face assessment with the interRAI Assessment Suite and a risk factor of a newly-emerged psychotic disorder suggestive of Schizophrenia herein called individuals with First Episode Psychosis (FEP). Individuals with FEP may have minimal service history.

   c. A HARP enrolled individual who either previously met the needs-based criteria above or has one of the needs based historical risk factors identified above; AND who is assessed and found that, but for the provision of BH HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).[2]

ii. All individuals in the HARP will be evaluated for eligibility for BH HCBS.

   a. Once an individual is enrolled in the HARP, a Health Home (or other State-designated entity) will initiate an independent person-centered planning

process to determine a plan of care.
   b. This will include the completion of an evaluation for BH HCBS eligibility.
   c. This process will comply with federal conflict-free case management requirements.

iii. Individuals determined eligible for the BH HCBS services based on the brief evaluation using the BH HCBS Eligibility Brief Assessment will receive a conflict-free functional assessment from an appropriately qualified individual.
   a. The assessment determines eligibility for BH HCBS and is used to establish a written, person-centered, individualized plan of care.
   b. Assessments are conducted using a BH HCBS Eligibility Assessment, a tool derived from the interRAI, a standardized clinical and functional assessment tool consistent with the State's approved Balancing Incentive Payment Program[3].

iv. The results of the functional assessment will be incorporated into the individual's person-centered plan of care.

v. These plans must be approved by the HARP or their designee.

vi. Reassessment of the plan of care (including need for BH HCBS) must be done at least annually; when the individual's circumstances or needs change significantly; or at the request of the individual. Plans may require more frequent reviews of plans of care to evaluate progress towards goals, determine if goals have been achieved or whether the plan of care requires revision.

Appendix B

Perception of Care Survey for Health and Recovery Plan (HARP) Members

Thank you for participating in this survey. Please take a moment to review this page for information and instructions.

Purpose of the Survey

This survey is sponsored by the New York State Offices of Mental Health, Office of Alcoholism and Substance Abuse Services and the Department of Health. NYS recently implemented specialized Medicaid Managed Care plans for individuals with behavioral health needs. The plans are designed to provide a wider array of specialty services, care coordination and assistance with things like employment and education.

According to our records, you're currently enrolled in _____. If you are not enrolled in this plan you do not need to complete the survey.

We're asking you to answer some questions about your experience with this plan as well as the care you received from providers and your perception of your own health and well-being. Your answers will help us continue to improve services and to identify what is working well in these plans.

This survey is specifically asking about the behavioral health services covered in your plan. This include services like counseling, treatment, inpatient, emergency, crisis or medicine for mental health or substance use issues. Please do NOT comment here about services that are NOT covered by your healthcare plan (e.g., self-help groups).

Voluntary and Confidential

- Your participation is voluntary. You may choose to complete this survey or not. The benefits and services you receive will not be affected whether you complete this survey or not. Your responses will remain confidential. Please do NOT write your name anywhere on the form.
- Your behavioral health providers will NOT have access to your individual responses.

Part I: BEHAVIORAL HEALTH SERVICES EXPERIENCE

1. Date (month and year) you last received behavioral health services _____
   ☐ If Unknown, check here
2. In the last 12 months, did you receive any treatment, counseling, or medicine for:
   a. Emotional or mental illness? ☐ Yes ☐ No
   b. Personal or family concerns? ☐ Yes ☐ No
   c. Alcohol use? ☐ Yes ☐ No
   d. Drug use? ☐ Yes ☐ No
   e. Tobacco use? ☐ Yes ☐ No
3. Are you currently receiving behavioral health services? ☐ No ☐ Yes → If Yes, Go To Question 5

4. Please select the ONE main reason why you are no longer receiving counseling or treatment.

☐ a. I no longer needed treatment because the problem that led to treatment was addressed.
☐ b. Treatment was not working as well as expected, so I stopped treatment with this provider.
☐ c. Treatment was no longer possible due to problems with transportation.

☐ d. Treatment was no longer possible due to problems paying for treatment.
☐ e. Treatment was no longer possible due to problems with finding time for treatment.
☐ f. Other reason(s) (please explain):

If you have not received behavioral health services in the past 12 months, skip to Part 3.

Part 2: ACCESS and QUALITY OF CARE

The next questions are about all the behavioral health services you got in the last 12 months that were covered by your healthcare plan. This include services like counseling, treatment, inpatient, emergency, crisis or medicine for mental health or substance use issues. Please consider those services when answering the questions below. Please do NOT comment here about services that are NOT covered by your healthcare plan (e.g., self-help groups). Respond even if you had only one visit in the last 12 months. If you have not received behavioral health services in the past 12 months, skip to Part 3.

In the last 12 months…	Never	Sometimes	Usually	Always	Source
5. How often did the people you went to for counseling or treatment explain things in a way you could understand?	○	○	○	○	**ECHO**
6. How often did the people you went to for treatment treat you with respect and kindness?	○	○	○	○	**ECHO**
7. How often did you get services at days/times that were convenient to you?	○	○	○	○	**CACS/MHS IP***
8. How often did you get services where you needed them?	○	○	○	○	**ECHO***
9. How often did you get the services you needed as soon as you wanted?	○	○	○	○	**ECHO**
10. How often did the people you went to for counseling or treatment spend enough time with you?	○	○	○	○	**ECHO**
11. How often did you feel safe when you were with the people you went to for counseling or treatment?	○	○	○	○	**ECHO**
12. How often did the people you went to for treatment listen carefully to you?	○	○	○	○	**ECHO**
13. How often were you involved as much as you wanted in your treatment?	○	○	○	○	**ECHO**

The following questions are about services that you may or may not receive through your healthcare plan. You would have received an assessment to determine if you were eligible for these services. For each of the services, please indicate whether you received the service from your healthcare plan in the past 12 months, and rate how helpful you found the services.

Possible Services in Your Plan of Care	**Received this service in the past 12 months?**				**If you received this service in the past 12 months, how helpful was the service?**		
	No, I did not need it	**No, but I needed it**	**Yes**		**Very Helpful**	**Somewhat Helpful**	**Not at All Helpful**
14. A Health Home care manager who coordinates your medical, behavioral health, and social service needs							
15. Peer support services (services provided by people who have experienced mental illness and/or substance use disorder and who work to help others with a mental illness and/or substance use disorder; e.g., recovery support, companionship during a crisis, assistance with self-help tools and helping with transitioning from the hospital to home)	○	○	○		○	○	○
16. Assistance with returning to school or a training program	○	○	○		○	○	○
17. Assistance with finding or maintaining a job							
18. Assistance with transportation other than medical transportation	○	○	○		○	○	○
19. Help with finding housing or better housing	○	○	○		○	○	○
20. Help in pursuing friendships and personal interests	○	○	○		○	○	○
21. Help in figuring out my finances, including getting any benefits I may be entitled to	○	○	○		○	○	○
22. Family support and training	○	○	○		○	○	○
23. Crisis respite services; i.e., residential care for 7 days or less, during a behavioral health crisis	○	○	○		○	○	○
24. Help with developing a crisis or relapse prevention plan	○	○	○		○	○	○

25. a. Does your language, race, religion, ethnic background or culture make any difference in the kind of behavioral health care <u>you need</u>? ☐ Yes ☐ No [proposed RCE transformation item]

b. If yes, in the *past 12* months, was the care (services) you received responsive to those needs? ☐ Yes ☐ No

26. Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all your counseling or treatment in the last 12 months? [ECHO #28]

0 1 2 3 4 5 6 7 8 9 10

27. In the last 12 months, how much were you helped by the counseling or treatment you got? [ECHO #29]

☐ Not at all ☐ Somewhat ☐ Very Much

28. a. In the last 12 months, did you take any prescription medicines as part of your treatment? ☐ Yes ☐ No → If No, Go to Question 29 [ECHO 16]
b. How often were you told what side effects of medicines to watch for? [ECHO 17 modified]
☐ Never ☐ Sometimes ☐ Usually ☐ Always

29. a. In the last 12 months, have you needed accommodations (for example wheelchair accessibility) in order to obtain services? ☐ Yes ☐ No → If No, Go to Question 30 [OMH item]
b. How often were accommodations you needed available? ☐ Never ☐ Sometimes ☐ Usually ☐ Always

Part 3: HEALTH, WELLNESS, AND QUALITY OF LIFE
The next questions are about your health. If you are unsure about how to answer a question, please give the best answer you can.

30. In general, how would you rate your overall mental or emotional health? *(Please select one)* [ECHO #30 modified]
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

31. In general, how would you rate your overall physical health? *(Please select one)* [ECHO #44 modified]
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

32. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health? *(Please select one)* [SF8]

None at all	Very little	Somewhat	Quite a lot	Could not do physical activities
☐	☐	☐	☐	☐

The following questions ask about how you are feeling now compared to 12 months ago. Please answer using the scale "Much Better" to "Much Worse."

Compared to 12 months ago, how would you rate…	**Much Better**	**A Little Better**	**About the Same**	**A Little Worse**	**Much Worse**	**Source**
33. your ability to deal with daily problems now?	○	○	○	○	○	**ECHO**
34. your ability to deal with social situations now?	○	○	○	○	○	**ECHO**
35. your ability to accomplish the things you want to do now?	○	○	○	○	○	**ECHO**
36. your problems or symptoms now?	○	○	○	○	○	**ECHO**

The next group of questions ask about how satisfied you feel, using the Zero to 10 scale. Zero means you feel no satisfaction at all. 10 means you feel completely satisfied. The middle of the scale is 5, which means you are neither happy nor sad. [PWI- A]

How satisfied are you with…… ?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
37. the things you have? Like the money you have and the things you own?	○	○	○	○	○	○	○	○	○	○	○
38. your health?	○	○	○	○	○	○	○	○	○	○	○
39. what you are achieving in life?	○	○	○	○	○	○	○	○	○	○	○
40. your personal relationships?	○	○	○	○	○	○	○	○	○	○	○
41. how safe you feel?	○	○	○	○	○	○	○	○	○	○	○
42. feeling part of your community?	○	○	○	○	○	○	○	○	○	○	○
43. how things will be later on in your life?	○	○	○	○	○	○	○	○	○	○	○

Following is a list of statements about your attitudes and beliefs about your health and wellness. There are no right or wrong answers. We just want to know what you think about these things. Read each statement and then decide how often you agree with it, from Never to Always.

	Never	**Sometimes**	**Usually**	**Always**	**Source**
44. I am confident that I can make positive changes in my life	○	○	○	○	**MD ARS-SF**
45. I am hopeful about the future	○	○	○	○	**MD ARS-SF**
46. I believe I make good choices in my life	○	○	○	○	**MD ARS-SF**
47. I am able to set my own goals in life	○	○	○	○	**MD ARS-SF**
48. I feel accepted as who I am	○	○	○	○	**MD ARS-SF**
49. I do things that are meaningful to me	○	○	○	○	**MD ARS-SF**
50. I am able to take care of my needs	○	○	○	○	**MD ARS-SF**
51. I am able to handle things when they go wrong	○	○	○	○	**MD ARS-SF**
52. I am able to do things that I want to do	○	○	○	○	**MD ARS-SF**

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Source**
53. I am aware of community supports available to me.	○	○	○	○	○	**RCE**
54. My living situation feels like home to me.	○	○	○	○	○	**RMQ**
55. I have access to reliable transportation.	○	○	○	○	○	**RCE***
56. I have trusted people I can turn to for help.	○	○	○	○	○	**RMQ**
57. I have at least one close relationship.	○	○	○	○	○	**RMQ**
58. I am involved in meaningful productive activities.	○	○	○	○	○	**RMQ**

59. Do you have comments about the behavioral health services that you received or would like to receive?

_____

_____

Part 4 - Background Information
The following information is collected to help ensure that services meet the needs of all individuals. Please do not share your name. Please check the boxes and fill in the blanks as applicable.

1. What is your zip code? _____
2. What is your age? _____
3. What was your sex at birth (on your original birth certificate)? ☐ Female ☐ Male ☐ Other
4. What is your gender identity? ☐ Female ☐ Male ☐ Other
5. How would you describe your sexual orientation ☐ Heterosexual or Straight ☐ Homosexual, gay or lesbian ☐ Bisexual ☐ Other ☐ Not sure ☐ Prefer not to answer
6. In what language do you prefer to receive your health care? ☐ English ☐Other (please specify)_____
7. Are you of Hispanic/Latino Origin?
   ☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino
8. What is your race? (Select all that apply)
   ☐ White ☐ American Indian/Alaska Native ☐ Asian
   ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other
9. Were you born in the United States? ☐ Yes ☐ No
10. What is your highest level of education completed?
    ☐ Less than High School ☐ High School diploma or GED ☐ Some college, no degree
    ☐ College degree or higher ☐ Business or technical school
11. Are you currently enrolled in school? ☐ Yes ☐ No
12. Are you currently enrolled in a job training program? ☐ Yes ☐ No
13. Have you been employed in the past 12 months? ☐ Yes, but I am not currently employed
    ☐ Yes, I am currently employed ☐ No

14. Please indicate whether the following things affect your ability to work or your decisions about working. Select all that apply to you.

a. Retired and no longer looking for work	○
a. Lack of good jobs	○
b. Concern about losing benefits (e.g., Medicaid, etc.)	○
c. Lack of transportation	○
d. Physical health condition	○
e. Mental health condition	○
f. Arrest history	○
g. Lack of job training / education	○
h. Medication side effects	○
i. Workplace attitudes about mental illness and/or substance use problems	○

15. Have you been arrested in the past 12 months? ☐ Yes ☐ No

16. Have you experienced any difficulties with your housing over the past 12 months (e.g., 3 or more moves, having no permanent address, being homeless, living in a shelter)? ☐ Yes ☐ No

Alcohol and Drugs	Yes	No
17. Do you think you have a problem with alcohol?	○	○
18. Do you think you have a problem with drugs?	○	○
19. Do you think you have a problem with tobacco?	○	○

THANK YOU FOR COMPLETING THE SURVEY.

Appendix C – List of Community Based Behavioral Health Specialty Services

The following are the community based behavioral health specialty services that MMC plans are required to offer in their benefit packages:

ACT
PROS
OMH Outpatient Clinic
Continuing Day Treatment
Partial Hospitalization
OASAS Opioid Treatment Program
OASAS Outpatient Clinic
Treatment for first episode psychosis

Appendix D
Data Sources

Medicaid Choice Enrollment Data NY Medicaid Choice Enrollment data

New York's enrollment broker, New York Medicaid Choice is collecting information to track the HARP enrollment process. The number of announcement, passive enrollment, and opt out acknowledgement letters distributed, number of announcement, passive enrollment, and opt out acknowledgement letters returned, number of members enrolled, number of members who opt out, and reasons for opting out are collected on an ongoing basis.

ONTrack NY Data System for tracking First Episode Psychosis treatment

OnTrackNY teams complete data collection forms to provide information on client outcomes and program functioning/services. Information about individual clients is collected through a Referral tracking form, an Admission form, Follow-up forms (submitted quarterly) and a Discharge form. Team-level information such as staffing, functioning and caseload is collected via a quarterly Program components form.

-Referral tracking form: referring organization and relationship to potential client, outcome of referral (eligibility evaluation results, declined or enrolled in OnTrackNY).

-Admission form: Demographic information (dob, gender, race, marital status, primary language), Educational background (highest grade, current status of school enrollment), Employment status and history (currently employed or not, job/internship history), Family background (education, employment status, primary language of primary support person), Previous psychiatric treatment (psychiatric hospitalizations and psychotropic medications prescribed), Medical & Substance use history, MIRECC GAF score (symptom, occupational functioning and social functioning scale).

-Follow-up form: Current primary diagnosis, Service utilization (met with SEES (Supported Education and Employment Specialist), list of core sessions completed), Current antipsychotic medications and side effects evaluation, Education and employment status during the assessment period, Substance use and behavioral concerns (violent behavior, suicide attempts), MIRECC GAF score

-Discharge form: Reason for discharge and post discharge services arranged, Education and employment status, Antipsychotic medications at time of discharge, Staff perspective on client outcomes (whether client's goals for education/employment/symptom management were met), MIRECC GAF score

-Program components form: Staffing (FTE devoted to team), Number of team meetings and % time spent on SEES (Supported Education and Employment Specialist)-related activities, Recruitment and evaluation activities (number of individuals contacted the program, number of individuals who began eligibility evaluation, number of individuals who were determined to be eligible).

The State is working to develop a Medicaid claims based algorithm which will be tested in collaboration with MMMC plans to develop capacity to identify incident cases of FEP using claims and potentially EHR data. This methodology is emergent at this time. The State anticipates that over the course of the Demonstration period that the identification of incident cases of FEP will become more robust.

Medicaid Managed Care HCBS Provider Network Data System

NYS OMH maintains a database containing information on providers who applied to provide BH HCBS. The database contains provider contact information, provider location, specific service(s)

provided, staff qualifications, and funding information. NYS OMH also will collect from MMC plans a list of BH HCBS providers that plans have contracted with.

Medicaid Claims

This database contains billing records for health care services, including pharmacy, for approximately 5.7 million individuals enrolled in Medicaid in a given year. Also included are data on Medicaid enrollment status, diagnoses and provider associated with the billed services. The Medicaid claims database is updated on a monthly basis to include additional claims and modifications to existing claims. Medicaid claims database will receive data from all managed care plans providing services to the demonstration population. Given the claims processing, there is a 6-month lag in the availability of complete and finalized Medicaid claims data, where data for a given year are considered final by June 30th of the following year.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®®)

The Health Plan version of the CAHPS®® survey will be administered to adults by NYSDOH every other year during the BH Demonstration period and will serve as the data source for selected member experience measures. The survey is administered by both mail and telephone, and assesses patients' experiences with health care providers and health plan staff. This includes information on patient experience with access to care, experiences with health care providers and health plan support. The survey includes standardized questionnaires for adults and children. Given confidentiality agreements, only de-identified CAHPS® data will be available for use. Data will be self-reported and from a sample of Medicaid Managed Care members. The experiences of the survey respondent population may be different than those of nonrespondents with respect to their health care services. Therefore, data users should consider the potential for non-response bias when interpreting CAHPS results.

BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment

The Uniform Assessment System contains the BH HCBS Eligibility Brief Assessment and BH HCBS Full Assessment data on HARP eligible individuals enrolled HARPs or HIV SNPS. Data include patient functional status, living situation, employment, education, behavioral health status, health status, cognitive functioning, and care preferences. The assessments include comprehensive sections on mental health state and substance use behaviors, including the following domains: Mental state indicators, Substance use or excessive behaviors, Harm to self and others, Behavior, Cognition, Stress and trauma. In terms of social functioning, the assessments include comprehensive sections on: Cognition, Functional status, Social relations, employment, education and finances, and environmental assessment. Data are a mix of self-reported information and information that is available to assessors through the care management process. Data users should consider the potential for self-reported items to be inaccurate.

HEDIS®/QARR Plan Reported Metrics

MMC plans, HARPs, and HIV SNPs will report HEDIS®/QARR data to NYS DOH annually. To supplement the QARR measurement set, the State will produce Behavioral Health Medicaid Outcome Measures at least annually. These reports will be based on Medicaid claims data and include measures related to inpatient discharge events and also measures related to outpatient care. The State accesses data in the Medicaid Data Mart. Encounter cost data is only available in the OHIP Data Mart. As a result, both Medicaid sources are cited below in Figure 2. The measures

will cover both the mental health and substance use disorder populations. Starting in the first year of implementation, metrics will be produced for the HARP* and MMMCO plans. Change over time in the above HEDIS®/QARR and NYS Behavioral Health Medicaid Outcome Measures will be examined.

Where there are gaps in HEDIS®/QARR utilization data, the State will produce service utilization measures. The State will monitor utilization of behavioral health services beginning in the first year of implementation. Monitoring will consist of utilization of services, cost, and encounter volume by behavioral health service. This monitoring will allow the State to determine if services are being provided at an appropriate volume. It is important that the transition of behavioral health services into managed care does not disrupt members' treatment. These reports will also allow the State to monitor utilization of the new BH HCBS.

HARP Perception of Care Survey

HARP members enrolled in HARP or HIV-SNP plans will be surveyed annually to measure perception of care and quality of life outcomes. The survey will be implemented by the EQRO using a random sampling methodology of HARP enrollees by product line for HARPs and HIV SNPs. The first survey is expected to be piloted in late 2016. The survey instrument will consist of approximately 50 questions and will be mailed to a random sample of eligible HARP members. Methods to improve response rate (e.g., web and mail survey administration, administration by peer advocates, sending reminders) from this representative sample are under review. Demographics will be collected, which will allow HARPs to monitor disparities. Data from this survey will allow the State and plans to monitor HARP members' perception of services and how their behavioral health services affect different areas of their life. Specific survey domains include Perception of Outcomes, Daily Functioning, Access to Services, Appropriateness of Services, Social Connectedness, and Quality of Life. Findings will be examined for change in BH services satisfaction levels over time. Data will be self-reported and from a sample of HARP members. The experiences of the survey respondent population may be different than those of nonrespondents with respect to their health care services. Therefore, data users should consider the potential for non-response bias when interpreting HARP PCS results.

Appendix E
BH HCBS Eligibility Brief Assessment **Tool**

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and Substance Abuse Services

Eligibility Assessment

PARTICIPANT INFORMATION

Name (First, Middle Initial, Last)

Medicaid ID (CIN) ☐☐☐☐☐☐☐☐☐☐

Date of Birth
☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Is person on HARP-eligible list?
O On HARP list
O Not on HARP list

IDENTIFICATION INFORMATION

Date of Assessment ☐☐ / ☐☐ / ☐☐☐☐

Reason for Assessment
O First assessment
O Routine reassessment
O Return assessment
O Significant change in status reassessment
O Exit assessment
O Eligibility denial/appeal
O Other (e.g., research)

What was individual's sex at birth? (on original birth certificate)
O Male
O Female
O Other

Gender Identity
O Male
O Female
O Other
O Could not (would not) answer

Sexual Orientation
O Heterosexual or straight
O Homosexual, gay, or lesbian
O Bisexual
O Other
O Not sure
O Could not (would not) answer

Marital Status
O Never married
O Married
O Partner/Significant Other
O Widowed
O Separated
O Divorced
O Unknown

Health Home where person is enrolled

Health Home Local Case ☐☐☐☐☐☐☐☐☐☐

Plan name if Health Home not known

What is person's religion?
O Roman Catholic
O Mainline Protestant
O Evangelical Protestant
O Non-denominational Protestant
O Historically Black Protestant
O Eastern Orthodox
O Latter-Day Saints (Mormon)
O Unknown
O Unspecified Christian
O Jewish
O Muslim
O Buddhist
O Hindu
O Other
O No religion

Residential/Living status at time of assessment
O Private home/apartment/rented room
O DOH adult home
O Homeless - shelter
O Homeless - street
O Mental Health supported/supportive housing (all types)
O OASAS/SUD community residence
O OCFS/ACS/DSS community residential program (Family foster care group home, Therapeutic foster care)
O OPWDD community residence
O Long-term care facility (nursing home)
O Rehabilitation hospital/unit
O Hospice facility/palliative care unit
O Acute care hospital
O Correctional facility
O Other

Living Arrangement
O Alone
O With spouse/partner only
O With spouse/partner and other(s)
O With child (not spouse/partner)
O With parent(s) or guardian(s)
O With sibling(s)
O With other relatives
O With non-relative(s)

Individual receives housing supports
O No O Yes

Residential Instability
Residential instability over LAST 2 YEARS (e.g., evicted from home, 3 or more moves, no permanent address, homeless, living in shelter)
O No O Yes

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and Substance Abuse Services

Eligibility Assessment

Cultural/Ethnic Information

Hispanic	O No	O Yes
If Hispanic is "Yes":		
Cuban	O No	O Yes
Mexican	O No	O Yes
Puerto Rican	O No	O Yes
Dominican	O No	O Yes
Ecuadorian	O No	O Yes
Other Hispanic	O No	O Yes
Unknown	O No	O Yes

Preferred Language

- O English
- O Spanish
- O American Sign language
- O Arabic
- O Cantonese
- O Fujianese
- O Mandarin
- O Other Chinese
- O French
- O German
- O Greek
- O Haitian/ French Creole
- O Other language not listed:
- O Hebrew
- O Hindi
- O Italian
- O Japanese
- O Korean
- O Polish
- O Russian
- O Tagalog
- O Urdu
- O Vietnamese
- O Yiddish
- O Unknown

Self-Identified Race/Ethnicity
(Check two most important racial/ethnic group identities)

- O White
- O Eastern European
- O Other European
- O Middle Eastern
- O Other white
- O Black
- O African-American
- O Afro-Caribbean
- O African Continent
- O Other black
- O Unknown black
- O American Indian or Alaska Native
- O Unknown American Indian or Alaska Native tribe
- O Asian
- O Chinese
- O Japanese
- O Asian Indian
- O Pakastani
- O Filipino
- O Vietnamese
- O Korean
- O Other Asian
- O Native Hawiian
- O Other Pacific islander
- O Unknown Native Hawaiian or Other Pacific Islander
- O Other
- O Unknown

ASSESSMENT INFORMATION

Mental Health Services

Time since last contact with community mental health agency or professional in PAST YEAR
(e.g., psychiatrist, social worker)
EXCLUDE THIS CONTACT

- O No contact in past year
- O 31 days or more
- O 30 days or less

Time since last psychiatric hospital discharge
Code for most recent instance in LAST 90 DAYS

- O No hospitalization within last 90 days
- O More than 30 days ago
- O 15 to 30 days ago
- O 8 to 14 days ago
- O Within in last 7 days
- O Now in hospital

Number Psychiatric Admissions in LAST 2 YEARS

- O None
- O 1 to 2
- O 3 or more

Number Lifetime Psychiatric Admissions

- O None
- O 1 to 3
- O 4 to 5
- O 6 or more

Addiction Treatment History
Code for time since last discharge from addiction treatment program or service

- O 30 days or less (from this program)
- O 30 days or less (from another program)
- O 31 - 90 days
- O 91 days to 1 year
- O More than 1 year
- O Not applicable (no prior admission or service)

Inpatient stay for substance use disorder

Number of inpatient rehabilitation admissions for substance use disorder in the past 6 months

- O None
- O 1 - 2
- O 3 or more

Number of inpatient detoxification admissions for substance use disorder in the past 6 months

- O None
- O 1 - 2
- O 3 or more

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and Substance Abuse Services

Eligibility Assessment

Alcohol
Highest number of drinks in any "single sitting" in LAST 14 DAYS

O None O 1 O 2 - 4 O 5 or more

Number of days in last 30 days consumed alcohol to point of intoxication
- O None
- O 1 day
- O 2 to 8 days
- O 9 or more days, but not daily
- O Daily

Time since use of the following substances

0 = Never
1 = More than 1 year ago
2 = 31 days to 1 year ago
3 = 8 to 30 days ago
4 = 4 to 7 days ago
5 = In last 3 days

	0	1	2	3	4	5
Inhalants (e.g., glue, gasoline, paint thinners, solvents)	O	O	O	O	O	O
Hallucinogens (e.g., phencyclidine or "angel dust", LSD or "acid", "magic mushrooms", "ecstasy")	O	O	O	O	O	O
Cocaine or crack	O	O	O	O	O	O
Stimulants (e.g., amphetamines, "uppers", "speed", methamphetamine, prescription stimulant not prescribed)	O	O	O	O	O	O
Heroin	O	O	O	O	O	O
Other opiates (including synthetics) (e.g., oxycodone, hydrocodone, or methadone not prescribed)	O	O	O	O	O	O
Marijuana not prescribed	O	O	O	O	O	O
Sedatives or anti-anxiety not prescribed	O	O	O	O	O	O

Intentional misuse of prescription or over-the-counter medication in LAST 90 DAYS
(e.g., used medication such as benzodiazepines or analgesics for purpose other than intended)

O No O Yes

Injection drug use
(Exclude prescription medications)
- O Never used injection drugs
- O Used injection drugs more than 30 days ago
- O Used injection drugs in last 30 days; did not share needles
- O Used injection drugs in last 30 days; did share needles

Overdose (ingestion of drugs or alcohol in an amount exceeding what the body can metabolize or excrete before toxicity)

Code for most recent time of event

- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Self-injurious ideation or attempt
Code for most recent instance

Considered performing self-injurious act
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Most recent self-injurious attempt
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Intent of any self-injurious attempt was to kill him/herself

O No O Yes O No attempt

Other indicators of self-injurious behavior

Family, caregiver, friend, or staff expresses concern that the person is at risk for self-injury

O No O Yes

Suicide plan - in LAST 30 DAYS, formulated a scheme to end own life

O No O Yes

Violence: Code for most recent instance

Violent ideation - (e.g., reports of pre-meditated thoughts, statements, plans to commit violence)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Intimidation of others or threatened violence - (e.g., threatening gestures or stance with no physical contact, shouting angrily, throwing furniture, explicit threats of violence)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Violence to others - Acts with **purposeful, malicious, or vicious** intent, resulting in physical harm to another (e.g., stabbing, choking, beating)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and
Substance Abuse Services

Eligibility Assessment

Police Intervention
Code for MOST RECENT instance (exclude contact as victim)

Arrested with charges
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Incarcerated (i.e., jail or prison with overnight stay)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Currently on probation or parole O No O Yes

Currently on court diversion/support program O No O Yes

Restraining order(s)
- O Never present
- O Previous order(s), but none present now
- O Order(s) present

Community treatment order(s) (AOT)
- O Not present
- O Present

Cognitive Skills for Daily Decision Making
Making decisions regarding tasks of daily life (e.g., when to get up or have meals, which clothes to wear or activities to do)
- O Independent - decisions consistent, reasonable and safe
- O Modified independence - some difficulty in new situations only
- O Minimally impaired - in specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times
- O Moderately impaired - decisions consistently poor or unsafe; cues/supervision required at all times
- O Severely impaired - never or rarely makes decisions
- O No discernible consciousness, coma

Acute Change in Mental Status from Person's Usual Functioning (e.g., restlessness, lethargy, difficult to arouse, altered environmental perception) O No O Yes

Independent Living Skills (IADLs)

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 = **Independent -** no help, setup, or supervision
1 = **Setup help only**
2 = **Supervision -** oversight/cuing
3 = **Limited assistance** - help on some occasions
4 = **Extensive assistance -** help throughout task, but performs 50% or more of task on own
5 = **Maximal assistance** - help throughout task, but performs less than 50% of task on own
6 = **Total dependence** - full performance by others during entire period
8 = **Activity did not occur** - during entire period (DO **NOT** USE THIS CODE IN SCORING CAPACITY)

	PERFORMANCE								CAPACITY							
	0	1	2	3	4	5	6	8	0	1	2	3	4	5	6	
Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
Phone use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	
Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, in and out of vehicles)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O	

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and Substance Abuse Services

Eligibility Assessment

Life Events
Code for most recent time of event

Codes:
0 = Never
1 = More than 1 year ago
2 = 31 days - 1 year ago
3 = 8 - 30 days ago
4 = 4 - 7 days ago
5 = In last 3 days

	0	1	2	3	4	5
Serious accident or physical impairment	O	O	O	O	O	O
Distressed about health of another person	O	O	O	O	O	O
Death of close family member or friend	O	O	O	O	O	O
Child custody issues; birth or adoption of child	O	O	O	O	O	O
Conflict-laden or severed relationship, including divorce	O	O	O	O	O	O
Failed or dropped out of education program	O	O	O	O	O	O
Major loss of income or serious economic hardship due to poverty	O	O	O	O	O	O
Review hearing (e.g., forensic, certification, capacity hearing)	O	O	O	O	O	O
Immigration, including refuge status	O	O	O	O	O	O
Lived in war zone or area of violent conflict (combatant or civilian)	O	O	O	O	O	O
Witnessed severe accident, disaster, terrorism, violence, or abuse	O	O	O	O	O	O
Victim of crime (e.g., robbery) - exclude assault	O	O	O	O	O	O
Victim of sexual assault or abuse	O	O	O	O	O	O
Victim of physical assault or abuse	O	O	O	O	O	O
Victim of emotional abuse	O	O	O	O	O	O
Parental abuse of alcohol and/or drugs	O	O	O	O	O	O

Person prefers change (when asked)
Peer supports (e.g., programs, staff)
O No O Yes
O Could/would not respond

Treatment Modalities
Code for treatment modalities used in LAST 30 DAYS (or since admission if less than 30 days ago)

0 = Not offered and not received
1 = Offered, but refused
2 = Not received, but scheduled to start within next 30 days
3 = Received 8 - 30 days ago
4 = Received in last 7 days

	0	1	2	3	4
Individual	O	O	O	O	O
Group	O	O	O	O	O
Family or couple	O	O	O	O	O
Self-help/consumer group (e.g., Double Trouble, Alcoholics Anonymous)	O	O	O	O	O
Complementary therapy or treatment	O	O	O	O	O
Day Hospital/Outpatient Program	O	O	O	O	O

Strengths

Reports having a confidant	O No	O Yes
Consistent positive outlook	O No	O Yes
Strong and supportive relationship with family	O No	O Yes
Reports strong sense of involvement in community	O No	O Yes

Social Relationships
[Note: Whenever possible, ask person]
Codes:
0 = Never
1 = More than 30 days ago
2 = 8 to 30 days ago
3 = 4 to 7 days ago
4 = In last 3 days
8 = Unable to determine

	0	1	2	3	4	8
Participation in social activities of long-standing interest	O	O	O	O	O	O
Visit with a long-standing social relation or family member	O	O	O	O	O	O
Other interaction with long-standing social relation or family member (e.g., telephone, email, text, social media)	O	O	O	O	O	O

Person prefers change (when asked)

Recreational activities (e.g., type, number, or level of participation)
O No O Yes
O Could/would not respond

Relationships (e.g., establishing friendships, improving existing relationships)
O No O Yes
O Could/would not respond

NEW YORK STATE

Office of Mental Health
Office of Alcoholism and Substance Abuse Services

Eligibility Assessment

Employment Status

- O Employed
- O Unemployed, seeking employment
- O Unemployed, not seeking employment

Employment Arrangements - Exclude volunteering

- O Integrated (competitive) without supports
- O Integrated (competitive) with supports (e.g., Transitional employment, intensive supportive employment, ongoing supported employment)
- O Non-integrated (non-competitive)
- O Not employed

Compensation for work - Exclude volunteer work

- O At or above minimum wage
- O Below minimum wage
- O No pay
- O Not employed

Volunteers
Works as a volunteer (e.g., for community services) O No O Yes

Highest level of education completed

- O No schooling
- O 8th grade or less
- O 9-11 grades
- O High school or GED
- O Business or technical school
- O Some college, no degree
- O Associate's degree
- O Bachelor's degree
- O Graduate degree

Enrolled in formal education program

- O No
- O Part-time
- O Full-time

Average hours worked per week in the past month - Exclude volunteer work

- O At least 35 hours
- O 10 - 34 hours
- O 1 - 9 hours
- O None
- O Not employed

Risk of unemployment or disrupted education

Increase in lateness or absenteeism over LAST 6 MONTHS	O No O Yes O Not applicable
Poor productivity or disruptiveness at work or school	O No O Yes O Not applicable
Expresses intent to quit work or school	O No O Yes O Not applicable
Persistent unemployment or fluctuating work history over LAST 2 YEARS	O No O Yes O Not applicable

Person prefers change (when asked)

Paid employment (e.g., type, hours, pay)	O No O Yes O Could/would not respond
Employment support services (e.g., pre-vocational services, transitional employment, Intensive supported employment, ongoing supported employment)	O No O Yes O Could/would not respond
Education/training	O No O Yes O Could/would not respond
Educational support services	O No O Yes O Could/would not respond

Finances
Because of limited funds, during the LAST 30 DAYS made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care O No O Yes

Psychiatric Diagnoses
(Mental Health and Substance Use Disorder)
Enter Axis I and Axis II DSM-IV diagnoses, if known. Must be completed on program discharge, but also complete with earlier assessments if specific psychiatric diagnosis already determined.

Axis I - DSM-IV code

_____

_____

Axis II - DSM-IV code

_____

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Eligibility Assessment

Intellectual Disability
(e.g., Down Syndrome) O No O Yes

Medical Diagnoses

Disease code
0 = Not present
2 = Diagnosis present, receiving active treatment
3 = Diagnosis present, monitored but no active treatment

	0	2	3
Asthma	O	O	O
Diabetes mellitus	O	O	O
Hypothyroidism	O	O	O
Migraine	O	O	O
Traumatic brain injury	O	O	O
Heart disease	O	O	O
HIV/AIDS	O	O	O
Chronic Obstructive Pulmonary Disease (COPD)	O	O	O
Hypertension	O	O	O
High cholesterol or triglycerides	O	O	O
Tuberculosis (either active or newly confirmed inactive infection)	O	O	O
Hepatitis C	O	O	O

Assessment Notes Comment on additional information that is pertinent to this individual or contributors to the assessment process:

Appendix F
BH HCBS Full Assessment **Tool**

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Community Mental Health Assessment

SECTION A: IDENTIFICATION INFORMATION

Name (First, Middle Initial, Last)

Medicaid ID (CIN) ☐☐☐☐☐☐☐☐☐☐

Social Security Number ☐☐☐-☐☐-☐☐☐☐

Date of Birth
☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Is person on HARP-eligible list?
- O On HARP list
- O Not on HARP list

Date of Assessment ☐☐ / ☐☐ / ☐☐☐☐

Reason for Assessment
- O First assessment
- O Routine reassessment
- O Return assessment
- O Significant change in status reassessment
- O Exit assessment
- O Other (e.g., research)

Health Home where person is enrolled

Health Home Local Case ☐☐☐☐☐☐☐☐☐☐

Plan name if Health Home not known

What was individual's sex at birth?
(on original birth certificate)
- O Male
- O Female
- O Other

Gender Identity
- O Male
- O Female
- O Other
- O Could not (would not) answer

Sexual Orientation
- O Heterosexual or straight
- O Homosexual, gay, or lesbian
- O Bisexual
- O Other
- O Not sure
- O Could not (would not) answer

What is person's religion?
- O Roman Catholic
- O Mainline Protestant
- O Evangelical Protestant
- O Non-denominational Protestant
- O Historically Black Protestant
- O Eastern Orthodox
- O Latter-Day Saints (Mormon)
- O Unknown
- O Unspecified Christian
- O Jewish
- O Muslim
- O Buddhist
- O Hindu
- O Other
- O No religion

Marital Status
- O Never married
- O Married
- O Partner/Significant Other
- O Widowed
- O Separated
- O Divorced
- O Unknown

Person's expressed goals of care
Identify primary goal

Capacity

Capable to consent to treatment	O No O Yes
Capable to disclose to information relating to clinical record	O No O Yes
Capable to manage property	O No O Yes
Has a substitute decision-maker for personal care or financial decisions	O No O Yes

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Residential/Living status at time of assessment

- O Private home/apartment/rented room
- O DOH adult home
- O Homeless - shelter
- O Homeless - street
- O Mental Health supported/supportive housing (all types)
- O OASAS/SUD community residence
- O OCFS/ACS/DSS community residential program (Family foster care group home, Therapeutic foster care)
- O OPWDD community residence
- O Long-term care facility (nursing home)
- O Rehabilitation hospital/unit
- O Hospice facility/palliative care unit
- O Acute care hospital
- O Correctional facility
- O Other

Living Arrangement

- O Alone
- O With spouse/partner only
- O With spouse/partner and other(s)
- O With child (not spouse/partner)
- O With parent(s) or guardian(s)
- O With sibling(s)
- O With other relatives
- O With non-relative(s)

Individual receives housing supports O No O Yes

Residential Instability
Residential instability over LAST 2 YEARS (e.g., evicted from home, 3 or more moves, no permanent address, homeless, living in shelter) O No O Yes

Comments, Section A

SECTION B: INTAKE AND INITIAL HISTORY

Reasons for Referral/Assessment

Threat or danger to self	O No	O Yes
Threat or danger to others	O No	O Yes
Inability to care for self due to mental illness	O No	O Yes
Problem with addiction or dependency	O No	O Yes
Specific psychiatric symptoms (e.g., depression, hallucinations, medication side effects)	O No	O Yes
Involvement with criminal justice system, or forensic admission	O No	O Yes

Date Case Opened ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

Cultural/Ethnic Information

Hispanic	O No	O Yes
If Hispanic is "Yes":		
Cuban	O No	O Yes
Mexican	O No	O Yes
Puerto Rican	O No	O Yes
Dominican	O No	O Yes
Ecuadorian	O No	O Yes
Other Hispanic	O No	O Yes
Unknown	O No	O Yes

Self-Identified Race/Ethnicity
(Check two most important racial/ethnic group identities)

- O White
- O Eastern European
- O Other European
- O Middle Eastern
- O Other white
- O Black
- O African-American
- O Afro-Caribbean
- O African Continent
- O Other black
- O Unknown black
- O American Indian or Alaska Native
- O Unknown American Indian or Alaska Native tribe
- O Asian
- O Chinese
- O Japanese
- O Asian Indian
- O Pakistani
- O Filipino
- O Vietnamese
- O Korean
- O Other Asian
- O Native Hawaiian
- O Other Pacific islander
- O Unknown Native Hawaiian or Other Pacific Islander
- O Other
- O Unknown

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Preferred Language

- O English
- O Spanish
- O American Sign language
- O Arabic
- O Cantonese
- O Fujianese
- O Mandarin
- O Other Chinese
- O French
- O German
- O Greek
- O Haitian/ French Creole
- O Other language not listed:
- O Hebrew
- O Hindi
- O Italian
- O Japanese
- O Korean
- O Polish
- O Russian
- O Tagalog
- O Urdu
- O Vietnamese
- O Yiddish
- O Unknown

Interpreter needed O No O Yes

Mental Health Services

Time since last contact with community mental health agency or professional in PAST YEAR (e.g., psychiatrist, social worker) EXCLUDE THIS CONTACT
- O No contact in past year
- O 31 days or more
- O 30 days or less

Time since last psychiatric hospital discharge
Code for most recent instance in LAST 90 DAYS
- O No hospitalization within last 90 days
- O More than 30 days ago
- O 15 to 30 days ago
- O 8 to 14 days ago
- O Within in last 7 days
- O Now in hospital

Number Psychiatric Admissions in LAST 2 YEARS
- O None
- O 1 to 2
- O 3 or more

Number Lifetime Psychiatric Admissions
- O None
- O 1 to 3
- O 4 to 5
- O 6 or more

Age in Years of First Overnight Stay in Psychiatric Hospital or Unit
- O Never
- O 1 to 14
- O 15 to 24
- O 25 to 44
- O 45 to 64
- O 65 +

History of Involuntary Psychiatric Admissions O No O Yes

Addiction Treatment History
Code for time since last discharge from addiction treatment program or service
- O 30 days or less (from this program)
- O 30 days or less (from another program)
- O 31 - 90 days
- O 91 days to 1 year
- O More than 1 year
- O Not applicable (no prior admission or service)

Inpatient stay for substance use disorder

Number of inpatient rehabilitation admissions for substance use disorder in the past 6 months
- O None
- O 1 - 2
- O 3 or more

Number of inpatient detoxification admissions for substance use disorder in the past 6 months
- O None
- O 1 - 2
- O 3 or more

Substance-related convictions
Code for tor all LIFETIME convictions

Drug possession
- O Never
- O Over 5 years
- O 1 - 5 years
- O 31 days to 1 year
- O Last 30 days

Distribution or making of drugs (includes illicit drugs, prescription medication, counterfeit prescription medication)
- O Never
- O Over 5 years
- O 1 - 5 years
- O 31 days to 1 year
- O Last 30 days

Driving under the influence
- O Never
- O Over 5 years
- O 1 - 5 years
- O 31 days to 1 year
- O Last 30 days

Comments, Section B

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Community Mental Health Assessment

SECTION C: MENTAL STATE INDICATORS

Mental State Indicators
Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: whenever possible, ask person]

0 = Not present **1** =Present but not exhibited in last 3 days **2** = Exhibited on 1-2 of last 3 days **3** = Exhibited daily in last 3 days

MOOD DISTURBANCE	0	1	2	3
Sad, pained, or worried facial expressions (e.g., furrowed brow, constant frowning)	O	O	O	O
Crying, tearfulness	O	O	O	O
Decreased energy - Statements of decrease in energy level (e.g., "I just don't feel like doing anything; I have no energy")	O	O	O	O
Made negative statements (e.g., "Nothing matters; Would rather be dead; What's the use; Regret having lived so long; Let me die")	O	O	O	O
Self-deprecation (e.g., "I am nothing; I am of no use to anyone")	O	O	O	O
Expressions of guilt or shame (e.g., "I've done something awful; This is all my fault; I am a terrible person")	O	O	O	O
Expressions of hopelessness (e.g.,"There's no hope for the future; Nothing's going to change for the better")	O	O	O	O
Inflated self-worth (e.g., exaggerated self-opinion, arrogance, inflated belief about one's own ability)	O	O	O	O
Hyper-arousal - Motor excitation; unusually high activity; increased reactivity	O	O	O	O
Irritability - Marked increase in being short-tempered or easily upset	O	O	O	O
Increased sociability or hypersexuality - Marked increase in social or sexual activity	O	O	O	O
Pressured speech or racing thoughts - Rapid speech, rapid transition from topic to topic	O	O	O	O
Labile affect - Affect fluctuates frequently with or without an external explanation	O	O	O	O
Flat or blunted affect - Indifference, non-responsiveness, hard to get to smile, etc.	O	O	O	O
ANXIETY				
Repetitive anxious complaints/concerns (non-health related) (e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationships)	O	O	O	O
Expressions, including non-verbal, of what appear to be unrealistic fears (e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations)	O	O	O	O
Obsessive thoughts - Unwanted ideas or thoughts that cannot be eliminated	O	O	O	O
Compulsive behavior (e.g., hand washing, repetitive checking of room, counting)	O	O	O	O
Intrusive thoughts or flashbacks - Disturbing memories or images that intrude into thoughts, unexpected recall of adverse events	O	O	O	O
Episodes of panic - Cascade of symptoms of fear, anxiety, loss of control	O	O	O	O
PSYCHOSIS				
Hallucinations - False sensory perception, of any type, with or without insight, without corresponding stimuli (e.g., auditory, visual, tactile, olfactory, gustatory hallucinations)	O	O	O	O
Command hallucinations - Hallucination directing the person to do something or to act in a particular manner (e.g., to harm self or others)	O	O	O	O
Delusions - Fixed false beliefs (e.g., grandiose, paranoid, somatic, excluding beliefs specific to person's culture or religion)	O	O	O	O
Abnormal thought processes (e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality)	O	O	O	O

[Note: Continued on next page]

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Community Mental Health Assessment

0 = Not present **1** =Present but not exhibited in last 3 days **2** = Exhibited on 1-2 of last 3 days **3** = Exhibited daily in last 3 days

NEGATIVE SYMPTOMS	0	1	2	3
Expressions (including non-verbal) of a lack of any pleasure in life (anhedonia) (e.g., "I don't enjoy anything anymore")	O	O	O	O
Withdrawal from activities of interest (e.g., long standing activities, being with family or friends, refusal to attend programs and activities)	O	O	O	O
Lack of motivation - Absence of spontaneous goal-directed activity	O	O	O	O
Reduced social interactions	O	O	O	O

OTHER INDICATORS				
Repetitive health complaints (e.g., persistently seeks medical attention, incessant concern with body functions)	O	O	O	O
Recurrent statements that something terrible is about to happen (e.g., believes he or she is about to die, have a heart attack)	O	O	O	O
Persistent anger with self or others (e.g., easily annoyed, anger at care received)	O	O	O	O
Unusual or abnormal physical movements - Unusual facial expressions or mannerisms; peculiar motor behavior or body posturing (e.g., stereotypies, waxy flexibility)	O	O	O	O
Hygiene -Unusually poor hygiene, unkempt, disheveled	O	O	O	O
Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep	O	O	O	O
Too much sleep - Excessive amount of sleep that interferes with person's normal functioning	O	O	O	O

Sleep problems related to hypomania or mania

Person had 24-hour period with less than 2 hours of sleep caused by increased energy level (Code for most recent instance)

- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Degree of Insight into Mental Health Problem

- O Full
- O Limited
- O None

Self-Reported Mood

0 = Not in last 3 days
1 = Not in last 3 days, but often feels that way
2 = In 1-2 of last 3 days
3 = Daily in last 3 days
8 = Person could not (would not) respond

Ask: *"In the last 3 days, how often have you felt..."*	0	1	2	3	8
Little interest or pleasure in things you normally enjoy?	O	O	O	O	O
Anxious, restless, or uneasy?	O	O	O	O	O
Sad, depressed, or hopeless?	O	O	O	O	O

Comments, Section C

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SECTION D: SUBSTANCE USE OR EXCESSIVE BEHAVIOR

Alcohol
Highest number of drinks in any "single sitting" in LAST 14 DAYS

O None O 1 O 2 - 4 O 5 or more

Number of days in last 30 days consumed alcohol to point of intoxication

O None
O 1 day
O 2 to 8 days
O 9 or more days, but not daily
O Daily

Time since use of the following substances

0 = Never
1 = More than 1 year ago
2 = 31 days to 1 year ago
3 = 8 to 30 days ago
4 = 4 to 7 days ago
5 = In last 3 days

	0	1	2	3	4	5
Inhalants (e.g., glue, gasoline, paint thinners, solvents)	O	O	O	O	O	O
Hallucinogens (e.g., phencyclidine or "angel dust", LSD or "acid", "magic mushrooms", "ecstasy")	O	O	O	O	O	O
Cocaine or crack	O	O	O	O	O	O
Stimulants (e.g., amphetamines, "uppers", "speed", methamphetamine, prescription stimulant not prescribed)	O	O	O	O	O	O
Heroin	O	O	O	O	O	O
Other opiates (including synthetics) (e.g., oxycodone, hydrocodone, or methadone not prescribed)	O	O	O	O	O	O
Marijuana not prescribed	O	O	O	O	O	O
Sedatives or anti-anxiety not prescribed	O	O	O	O	O	O

Intentional misuse of prescription or over-the-counter medication in LAST 90 DAYS
(e.g., used medication such as benzodiazapines or analgesics for purpose other than intended)

O No O Yes

High risk consumption
Code for any consumption of unconventional, highly dangerous substances for the purpose of intoxication in the last 90 days (e.g., hand sanitizer, antifreeze, large quantity of nutmeg)

O No O Yes

Injection drug use
(Exclude prescription medications)

O Never used injection drugs
O Used injection drugs more than 30 days ago
O Used injection drugs in last 30 days; did not share needles
O Used injection drugs in last 30 days; did share needles

Patterns of drinking or other substance use in last 90 days
Presence of behavioral indicators of potential substance-related addiction in LAST 90 DAYS

Person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use O No O Yes

Person has been bothered by criticism from others about drinking or drug use O No O Yes

Person has reported feelings of guilt about drinking or drug use O No O Yes

Person had to have a drink or use drugs first thing in the morning to steady nerves (e.g., an "eye opener") O No O Yes

Person feels social environment encourages or facilitates abuse of drugs or alcohol O No O Yes

Abstinence History

Longest period of abstinence in last 5 years (excluding tobacco products and over-the-counter or prescribed medications as recommended by a physician)

O More than 2 years
O 91 days to 2 years
O 90 days or less
O 30 days or less
O No periods of abstinence
O Not applicable

Most recent episode of abstinence in last 5 years

O More than 2 years
O 91 days to 2 years
O 90 days or less
O 30 days or less
O No periods of abstinence
O Not applicable

Withdrawal symptoms
Severity of signs and symptoms possibly indicative of withdrawal from alcohol, drugs, or medication. Code for most severe level in LAST 3 DAYS.

O None present
O Mild - Symptoms typical of early stages of withdrawal (e.g., agitation, "jitters", cravings, gastrointestinal upset, anxiety, hostility, vivid dreaming)
O Moderate - Increased severity of early indicators (e.g., weakness, sweating, hot flashes, fainting, muscle twitching)
O Severe - Symptoms typical of late stages of withdrawal (e.g., exhaustion, seizures, tremors, tachycardia, disorientation, hyperventilation)

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Overdose (ingestion of drugs or alcohol in an amount exceeding what the body can metabolize or excrete before toxicity)

Code for most recent time of event

- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Person has ever had a diagnosis of substance-related disorder (e.g., alcohol dependence) — O No O Yes

Caffeine Use
Highest number of caffeinated beverages consumed in any single day of the LAST 3 DAYS

- O No coffee or caffeinated beverages
- O 1-2 cups of coffee or 1-4 caffeinated beverages
- O 3-5 cups of coffee or 5-9 caffeinated beverages
- O 6 or more cups of coffee or 10 or more caffeinated beverages

Uses tobacco daily

- O No
- O Not in last 3 days, but is usually a daily user
- O Yes

Gambled excessively or uncontrollably in LAST 90 DAYS — O No O Yes

Problem video gaming and Internet use in LAST 90 DAYS
Code for disruption caused by the person's usual pattern of video gaming or Internet use

0 = None

1 = Minimal - Some disruption, but completes normal day-to-day activities, attends to paid and unpaid work responsibilities (e.g., competitive employment, school, parenting, household chores)

2 = Moderate - Due to problem video gaming/Internet use, reduced attention to personal needs (e.g., hygiene, sleeping, eating): limited in-person social activity outside of video gaming/on-line interactions, poor productivity and attendance at work or school

3 = Severe - Due to problem video gaming/Internet use, does not attend to personal needs; negligible participation in in-person social or household activities; not attending work or school, or at serious risk of workplace dismissal or failure at school

	0	1	2	3
Problem with video gaming	O	O	O	O
Problem Internet use	O	O	O	O

Comments, Section D

SECTION E: HARM TO SELF AND OTHERS

Self-injurious ideation or attempt
Code for most recent instance

Considered performing self-injurious act

- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Most recent self-injurious attempt

- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Intent of any self-injurious attempt was to kill him/herself

- O No
- O Yes
- O No attempt

Other indicators of self-injurious behavior

Family, caregiver, friend, or staff expresses concern that the person is at risk for self-injury — O No O Yes

Suicide plan - in LAST 30 DAYS, formulated a scheme to end own life — O No O Yes

Violence: Code for most recent instance

Violent ideation - (e.g., reports of pre-meditated thoughts, statements, plans to commit violence)

- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

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Intimidation of others or threatened violence - (e.g., threatening gestures or stance with no physical contact, shouting angrily, throwing furniture, explicit threats of violence)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Violence to others - Acts with **purposeful, malicious, or vicious** intent, resulting in physical harm to another (e.g., stabbing, choking, beating)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

History of sexual violence or assault as perpetrator O No O Yes

Extreme behavior disturbance
History of extreme behavior(s) that suggests serious risk of harm to self (e.g., severe self-mutilation) or others (e.g., fire setting, homicide)
- O No
- O Yes, but not exhibited in last 7 days
- O Yes, exhibited in last 7 days

Police Intervention
Code for MOST RECENT instance (exclude contact as victim)

Police intervention for violent behavior
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Police intervention for non-violent behavior
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Arrested with charges
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Incarcerated (i.e., jail or prison with overnight stay)
- O Never
- O More than 1 year ago
- O 31 days - 1 year ago
- O 8 - 30 days ago
- O 4 - 7 days ago
- O In last 3 days

Currently on probation or parole O No O Yes

Currently on court diversion/support program O No O Yes

Restraining order(s)
- O Never present
- O Previous order(s), but none present now
- O Order(s) present

Community treatment order(s) (AOT)
- O Not present
- O Present

Comments, Section E

SECTION F: BEHAVIOR

Behavioral Symptoms
Code for indicators observed in last 3 days irrespective of the assumed cause
0. Not present **1.** Present but not exhibited in last 3 days
2. Exhibited 1-2 of last 3 days **3.** Exhibited daily in last 3 days

	0	1	2	3
Wandering - moved with no rational purpose, seemingly oblivious to needs or safety	O	O	O	O
Verbal abuse (e.g., others were threatened, screamed at, cursed at)	O	O	O	O
Physical abuse (e.g., others were hit, shoved, scratched)	O	O	O	O
Socially inappropriate or disruptive behavior (e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through other's belongings, banging, rocking, seeking touch from other)	O	O	O	O
Inappropriate public sexual behavior or public disrobing	O	O	O	O
Resists care (e.g., taking medications/injections, ADL assistance, eating)	O	O	O	O

Comments, Section F

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SECTION G: COGNITION

Cognitive Skills for Daily Decision Making
Making decisions regarding tasks of daily life (e.g., when to get up or have meals, which clothes to wear or activities to do)

- O Independent - decisions consistent, reasonable and safe
- O Modified independence - some difficulty in new situations only
- O Minimally impaired - in specific recurring situations, decisions become poor or unsafe; cues/supervision necessary at those times
- O Moderately impaired - decisions consistently poor or unsafe; cues/supervision required at all times
- O Severely impaired - never or rarely makes decisions
- O No discernible consciousness, coma

Memory/Recall Ability Code for recall of what was learned or known

Short-term memory OK - seems/appears to recall after 5 minutes — O Yes, memory OK / O Memory problem

Procedural memory OK - Can perform all or almost all steps in a multi-task sequence without cues — O Yes, memory OK / O Memory problem

Periodic Disordered Thinking or Awareness
[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time.]

Codes:
0 = Behavior not present
1 = Behavior present, consistent with usual functioning
2 = Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

	0	1	2
Easily distracted (e.g., episodes of difficulty paying attention; gets sidetracked)	O	O	O
Episodes of disorganized speech (e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	O	O	O
Mental function varies over the course of the day (e.g., sometimes better, sometimes worse)	O	O	O

Acute Change in Mental Status from Person's Usual Functioning (e.g., restlessness, lethargy, difficult to arouse, altered environmental perception) — O No O Yes

Change in Decision Making as Compared to 90 DAYS AGO (or since last **assessment**)
- O Improved
- O No change
- O Declined
- O Uncertain

Comments, Section G

SECTION H: FUNCTIONAL STATUS

Independent Living Skills (IADLs)

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 = Independent - no help, setup, or supervision
1 = Setup help only
2 = Supervision - oversight/cuing
3 = Limited assistance - help on some occasions
4 = Extensive assistance - help throughout task, but performs 50% or more of task on own
5 = Maximal assistance - help throughout task, but performs less than 50% of task on own
6 = Total dependence - full performance by others during entire period
8 = Activity did not occur - during entire period (DO **NOT** USE THIS CODE IN SCORING CAPACITY)

	PERFORMANCE								CAPACITY						
	0	1	2	3	4	5	6	8	0	1	2	3	4	5	6
Meal preparation - How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O
Ordinary housework - How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	O	O	O	O	O	O	O	O	O	O	O	O	O	O	O

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	PERFORMANCE 0 1 2 3 4 5 6 8	CAPACITY 0 1 2 3 4 5 6
Managing finances - How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored	O O O O O O O O	O O O O O O O
Managing medications - How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)	O O O O O O O O	O O O O O O O
Phone use - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)	O O O O O O O O	O O O O O O O
Shopping - How shopping is performed for food and household items (e.g., selecting items, paying money) EXCLUDE TRANSPORTATION	O O O O O O O O	O O O O O O O
Transportation - How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, in and out of vehicles)	O O O O O O O O	O O O O O O O

Self-Care Skills (ADLs) Performance

Consider all episodes over 3-day period.

If **all** episodes are performed at the same level, score ADL at that level. If **any** episodes at level 6, and others less dependent, score ADL as a 5.

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2 - 5.

0 = Independent - no physical assistance, setup, or supervision in any episode
1 = Independent, setup help only - article or device provided or placed within reach, no physical assistance or supervision in any episode
2 = Supervision - oversight/cuing
3 = Limited assistance - guided maneuvering of limbs, physical guidance without taking weight
4 = Extensive assistance - weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5 = Maximal assistance - weight-bearing support (including lifting limbs) by 2+ helpers -OR- weight-bearing support for more than 50% of subtasks
6 = Total dependence - full performance by others during all episodes
8 = Activity did not occur during entire period

	0 1 2 3 4 5 6 8
Personal Hygiene - How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS	O O O O O O O O
Locomotion - How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair	O O O O O O O O
Transfer toilet - How moves on and off toilet or commode	O O O O O O O O
Toilet Use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET	O O O O O O O O
Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	O O O O O O O O

Total hours of exercise or physical activity in LAST 3 DAYS (e.g., walking)

O None
O Less than 1 hour
O 1 - 2 hours
O 3 - 4 hours
O More than 4 hours

Physical Function Improvement Potential

Person believes he/she is capable of improved performance in physical function O No O Yes

Care professional believes person is capable of improved performance in physical function O No O Yes

Change in ADL Status as compared to 90 days ago, or since last assessment if less than 90 days ago

O Improved
O No change
O Declined
O Uncertain

Comments, Section H

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SECTION I: COMMUNICATION AND VISION

Making Self Understood (Expression)
Expressing information content - both verbal and non-verbal

- O Understood - expresses ideas without difficulty
- O Usually understood - difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
- O Often understood - difficulty finding words or finishing thoughts AND prompting usually required
- O Sometimes understood - ability is limited to making concrete requests
- O Rarely or never understood

Ability to Understand Others (Comprehension)
Understanding verbal information content (however able; with hearing appliance normally used)

- O Understands - clear comprehension
- O Usually understands - misses some part/intent of message BUT comprehends most conversation
- O Often understands - misses some part/intent of message BUT with repetition or explanation can often comprehend conversation
- O Sometimes understands - responds adequately to simple, direct communication only
- O Rarely or never understands

Hearing: Ability to hear (with hearing appliance normally used)

- O Adequate - no difficulty in normal conversation, social interaction, listening to TV
- O Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
- O Moderate difficulty - problem hearing normal conversation, requires quiet setting to hear well
- O Severe difficulty - difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- O No hearing

Vision: Ability to see in adequate light (with glasses or with other visual appliance normally used)

- O Adequate - sees fine detail, including regular print in newspaper/books
- O Minimal difficulty - sees large print, but not regular print in newspaper/books
- O Moderate difficulty - limited vision; not able to see newspaper headlines; but can identify objects
- O Severe difficulty - object identification in question, but eyes appear to follow objects; sees only light, color, shapes
- O No vision

Comments, Section I

SECTION J: HEALTH CONDITIONS

Self-Reported Health
Ask: *"In general, how would you rate your health?"*

- O Excellent
- O Good
- O Fair
- O Poor
- O Could not (would not) respond

Problem Frequency
Code for presence LAST 3 DAYS

- **0** = Not present
- **1** = Present but not exhibited in last 3 days
- **2** = Exhibited on 1 of last 3 days
- **3** = Exhibited on 2 of last 3 days
- **4** = Exhibited daily in last 3 days

	0	1	2	3	4
Balance					
Dizziness	O	O	O	O	O
Unsteady gait	O	O	O	O	O
Cardiac	0	1	2	3	4
Chest pain	O	O	O	O	O

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Problem Frequency **0** = Not present
1 = Present but not exhibited in last 3 days
Code for presence LAST 3 DAYS **2** = Exhibited on 1 of last 3 days
3 = Exhibited on 2 of last 3 days
4 = Exhibited daily in last 3 days

GI Status	0	1	2	3	4
Acid Reflux - Regurgitation of acid from stomach to throat	O	O	O	O	O
Constipation - No bowel movement in 3 days or difficult passage of hard stool	O	O	O	O	O
Diarrhea	O	O	O	O	O
Dry mouth	O	O	O	O	O
Hypersalivation or drooling	O	O	O	O	O
Increase or decrease in normal appetite	O	O	O	O	O
Nausea	O	O	O	O	O
Vomiting	O	O	O	O	O
Other	0	1	2	3	4
Blurred vision	O	O	O	O	O
Daytime drowsiness or sedation	O	O	O	O	O
Difficulty urinating, urinating 3 or more times a night or polyuria	O	O	O	O	O
Emergent conditions (e.g., itching, fever, rash, bleeding)	O	O	O	O	O
Headache	O	O	O	O	O
Peripheral edema	O	O	O	O	O
Seizures	O	O	O	O	O

Dyspnea (Shortness of breath)

- O Absence of symptom
- O Absent at rest, but present when performed moderate activities
- O Absent at rest, but present when performed normal day-to-day activities
- O Present at rest

Fatigue
Inability to complete normal daily activities (e.g., ADLs, IADLs)

- O None
- O Minimal - Diminished energy but completes normal day-to-day activities
- O Moderate - Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
- O Severe - Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
- O Unable to commence any normal day-to-day activities - Due to diminished energy

Falls				
	Last 30 days	O No falls	O 1 fall	O 2+ falls
	31 - 90 days	O No falls	O 1 fall	O 2+ falls
	91 - 180 days	O No falls	O 1 fall	O 2+ falls

Pain Symptoms
[Note: Always ask person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)

- O No pain
- O Present but not exhibited in last 3 days
- O Exhibited on 1-2 of last 3 days
- O Exhibited daily in last 3 days

Intensity of highest level of pain present

- O No pain
- O Mild
- O Moderate
- O Severe
- O Times when pain is horrible or excruciating

Consistency of pain

- O No pain
- O Single episode during last 3 days
- O Intermittent
- O Constant

Pain Control - Adequacy of current therapeutic regimen to control pain (from person's point of view)

- O No issue of pain
- O Pain intensity acceptable to person; no treatment regimen or change in regimen required
- O Controlled adequately by therapeutic regimen
- O Controlled when therapeutic regimen followed, but not always followed as ordered
- O Therapeutic regimen followed, but pain control not adequate
- O No therapeutic regimen being followed for pain; pain not adequately controlled

Comments, Section J

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SECTION K: STRESS AND TRAUMA

Life Events
Code for most recent time of event

Codes:
0 = Never
1 = More than 1 year ago
2 = 31 days - 1 year ago
3 = 8 - 30 days ago
4 = 4 - 7 days ago
5 = In last 3 days

	0	1	2	3	4	5
Serious accident or physical impairment	O	O	O	O	O	O
Distressed about health of another person	O	O	O	O	O	O
Death of close family member or friend	O	O	O	O	O	O
Child custody issues; birth or adoption of child	O	O	O	O	O	O
Conflict-laden or severed relationship, including divorce	O	O	O	O	O	O
Failed or dropped out of education program	O	O	O	O	O	O
Major loss of income or serious economic hardship due to poverty	O	O	O	O	O	O
Review hearing (e.g., forensic, certification, capacity hearing)	O	O	O	O	O	O
Immigration, including refuge status	O	O	O	O	O	O
Lived in war zone or area of violent conflict (combatant or civilian)	O	O	O	O	O	O
Witnessed severe accident, disaster, terrorism, violence, or abuse	O	O	O	O	O	O
Victim of crime (e.g., robbery) - exclude assault	O	O	O	O	O	O
Victim of sexual assault or abuse	O	O	O	O	O	O
Victim of physical assault or abuse	O	O	O	O	O	O
Victim of emotional abuse	O	O	O	O	O	O
Parental abuse of alcohol and/or drugs	O	O	O	O	O	O

Describes one or more of these life events as invoking a sense of horror or intense fear

O No, or not applicable
O Yes
O Could not/would not respond

Other Indicators of Abuse of Person

Fearful of a family member or close acquaintance	O No	O Yes
Unexplained injuries	O No	O Yes
Person has concerns for his/her safety	O No	O Yes
Family member(s) have been victims of physical, emotional, sexual abuse or assault	O No	O Yes

Comments, Section K

SECTION L: MEDICATIONS

List of All Medications
List all active prescriptions and any non-prescribed (over the counter) medications **taken in the LAST 3 DAYS**
Use worksheet on following page

Adherent with Medications Prescribed by Physician

O Always adherent
O Adherent 80% of time or more
O Adherent less than 80% of time, including failure to purchase prescribed medications
O No medications prescribed

Stopped taking psychotropic medication in last 3 months because of side effects

O No, or no psychotropic medications
O Yes

Allergy to Any Drug

O No known drug allergies
O Yes

Comments, Section L

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SECTION L: MEDICATIONS

List of All Medications
List all active prescriptions and any non-prescribed (over the counter) medications **taken in the LAST 3 DAYS**

Dose:
Positive number, such as 0.5, 5, 150

Unit Codes:
gtts (drops)
gm (gram)
L (liter)
mcg (microgram)
mEq (milli-equiv)
mg (milligram)
ml (milliliter)
oz (ounce)
OTH (other)

Route Codes:
PO (By mouth/oral)
SL (Sublingual)
IM (Intramuscular)
IV (Intravenous)
Sub-Q (Subcutaneous)
REC (Rectal)
TOP (Topical)
IH (Inhalation)
NAS (Nasal)
ET (Enteral tube)
TD (Transdermal)
EYE (Eye)
OTH(Other)

PRN Codes: **Y** = yes **N** = no

Frequency Codes:
Q1H (Every hour)
Q2H (Every 2 hours)
Q3H (every 3 hours)
Q4H (Every 4 hours)
Q6H (Every 6 hours)
Q8H (Every 8 hours)
QD (Daily)
BED (Bedtime)
QHS (Hours of sleep)
BID (2 times daily)
TID (3 times daily)
QID (4 times daily)
5D (5 times daily)
Q2D (Every other day)
Q3D (Every three days)
Weekly
2W (2 times weekly)
3W (3 times weekly)
4W (4 times weekly)
5W (5 times weekly)
6W (6 times weekly)
1M (Monthly)
2M (Twice each mo)
OTH (Other)

Name	Dose	Unit	Route	Frequency	PRN

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SECTION M: SERVICE UTILIZATION AND TREATMENTS

Formal Care
Contact with formal care provider in LAST 30 DAYS (or since move to current residence if LESS THAN 30 DAYS)

0 = No contact in last 30 days
1 = No contact in last 7 days, but contact 8 - 30 days ago
2 = Contact in last 7 days, but not daily
3 = Daily contact in last 7 days

	0	1	2	3
Psychiatrist or psychiatric nurse practitioner	O	O	O	O
Nurse practitioner or MD (non-psychiatrist)	O	O	O	O
Mental Health/Substance Abuse Counselor	O	O	O	O
Social Worker	O	O	O	O
Psychologist or Psychometrist	O	O	O	O
Occupational Therapist	O	O	O	O
Employment/Educational Counselor	O	O	O	O
Nurse	O	O	O	O
Personal Support Worker/Health Care Aide	O	O	O	O
Behavioral health peer support (paid)	O	O	O	O
Other behavioral health staff (including CASACs)	O	O	O	O

Person prefers change (when asked)

Peer supports (e.g., programs, staff)

O No O Yes
O Could/would not respond

Treatment Modalities
Code for treatment modalities used in LAST 30 DAYS (or since admission if less than 30 days ago)

0 = Not offered and not received
1 = Offered, but refused
2 = Not received, but scheduled to start within next 30 days
3 = Received 8 - 30 days ago
4 = Received in last 7 days

	0	1	2	3	4
Individual	O	O	O	O	O
Group	O	O	O	O	O
Family or couple	O	O	O	O	O
Self-help/consumer group (e.g., Double Trouble, Alcoholics Anonymous)	O	O	O	O	O
Complementary therapy or treatment	O	O	O	O	O
Day hospital/Outpatient program	O	O	O	O	O

Focus of Intervention
Code for types of issues that were a major focus of interventions in LAST 30 DAYS (or since admission if less than 30 days ago)

0 = No intervention of this type
1 = Offered, but refused
2 = Not received, but scheduled to start within next 30 days
3 = Received 8 to 30 days ago
4 = Received in last 7 days

	0	1	2	3	4
Life skills training	O	O	O	O	O
Social of family functioning	O	O	O	O	O
Detoxification or post-detox stabilization	O	O	O	O	O
Alcohol or drug treatment, including methadone management	O	O	O	O	O
Employment support services	O	O	O	O	O
Anger management	O	O	O	O	O
Behavioral management	O	O	O	O	O
Pain management	O	O	O	O	O
Crisis intervention	O	O	O	O	O
Basic needs (e.g., shelter, food)	O	O	O	O	O
Psychosocial rehabilitation	O	O	O	O	O

Electroconvulsive Therapy

O Never received and not scheduled to begin
O Received more than 30 days ago
O Received 8 to 30 days ago
O Received within last 7 days
O Scheduled to begin within 7 days

Hospital Use, Emergency Room Use, Physician Visit

Code for number of times during the LAST 90 DAYS (or since last assessment if less than 90 days)

Inpatient acute hospital with overnight stay (non-psychiatric) ☐☐

Emergency room visit (not counting overnight stay) ☐☐

Physician visit (or authorized assistant or practitioner) - EXCLUDE PSYCHIATRIST ☐☐

Comments, Section M

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SECTION N: NUTRITIONAL STATUS

Height and Weight
Record height in inches and weight in pounds.

Height ☐☐ **Inches**

Weight
Base weight on most recent measure in LAST 30 DAYS ☐☐☐ **Pounds**

Nutritional Issues

Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS	O No	O Yes
Weight gain of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS	O No	O Yes
Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day)	O No	O Yes
Decrease in amount of food or fluid usually consumed	O No	O Yes
Ate one or fewer meals on AT LEAST 2 of LAST 3 DAYS	O No	O Yes

Presence of potential signs of eating disorders in LAST 30 DAYS

Any instances of binge eating, purging, or bulimia	O No	O Yes
Unrealistic fear of weight gain; statements that suggest a distorted body image	O No	O Yes
Fasting or major restrictions of diet - EXCLUDE RELIGIOUS PRACTICES	O No	O Yes

Comments, Section N

SECTION O: SOCIAL RELATIONS

Two Key Informal Helpers

Helper 1 Name: _____

Relationship to person

O Child or child-in-law
O Spouse
O Partner/significant other
O Parent/guardian
O Sibling
O Other relative
O Friend
O Neighbor
O No informal helper

Lives with person

O No
O Yes, 6 months or less
O Yes, more than 6 months
O No informal helper

Areas of informal help during last 3 days
(Check all that apply)

Help with child care or other dependents	O No O Yes	O No informal helper
Supervision for personal safety	O No O Yes	O No informal helper
Crisis support	O No O Yes	O No informal helper
IADL	O No O Yes	O No informal helper
ADL	O No O Yes	O No informal helper

Helper 2 Name: _____

Relationship to person

O Child or child-in-law
O Spouse
O Partner/significant other
O Parent/guardian
O Sibling
O Other relative
O Friend
O Neighbor
O No support

Lives with person

O No
O Yes, 6 months or less
O Yes, more than 6 months
O No informal helper

Areas of informal help during last 3 days
(Check all that apply)

Help with child care or other dependents	O No O Yes	O No informal helper
Supervision for personal safety	O No O Yes	O No informal helper
Crisis support	O No O Yes	O No informal helper
IADL	O No O Yes	O No informal helper
ADL	O No O Yes	O No informal helper

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Plans for Future Needs
Person or informal helper(s) has plans for alternative future support or living arrangements, if required (e.g., if current informal helper is no longer able to provide support)

- O Alternative plans not considered OR not required
- O Alternative plans not made, but under consideration
- O Alternative plans made

Informal Helper Status

Informal helper(s) is unable to continue caring activities (e.g., decline in health of the helper makes it difficult to continue)	O No	O Yes
Primary informal helper expresses feelings of distress, anger, or depression	O No	O Yes
Family or close friends report feeling overwhelmed by person's illness	O No	O Yes

Belief that relationship(s) with immediate family member(s) is disturbed or dysfunctional

- O Belief not present
- O Only person believes
- O Family, friends, or other believe
- O Both person AND others believe

Unsettled Relationships

Conflict with or repeated criticism of family or friends	O No	O Yes
Conflict with or repeated criticism of other care recipients	O No	O Yes
Staff report persistent frustration in dealing with person	O No	O Yes

Strengths

Reports having a confidant	O No	O Yes
Consistent positive outlook	O No	O Yes
Strong and supportive relationship with family	O No	O Yes
Reports strong sense of involvement in community	O No	O Yes

Social Relationships
[Note: Whenever possible, ask person]
Codes:
0 = Never **3** = 4 to 7 days ago
1 = More than 30 days ago **4** = In last 3 days
2 = 8 to 30 days ago **8** = Unable to determine

	0	1	2	3	4	8
Participation in social activities of long-standing interest	O	O	O	O	O	O
Visit with a long-standing social relation or family member	O	O	O	O	O	O
Other interaction with long-standing social relation or family member (e.g., telephone, email, text, social media)	O	O	O	O	O	O

Person prefers change (when asked)

Recreational activities (e.g., type, number, or level of participation)	O No O Could/would not respond	O Yes
Relationships (e.g., establishing friendships, improving existing relationships)	O No O Could/would not respond	O Yes

Activity Level
In the LAST 3 DAYS, number of days went out of the house or building in which he/she lives (no matter how short the period)

- O No days out
- O Did not go out in last 3 days, but usually goes out over a 3-day period
- O 1 - 2 days
- O 3 days

Length of time alone during the day (morning and afternoon)

- O Less than 1 hour
- O 1 to 2 hours
- O More than 2 hours, but less than 8 hours
- O 8 hours or more

Comments, Section O

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SECTION P: EMPLOYMENT, EDUCATION, AND FINANCES

Employment Status
- O Employed
- O Unemployed, seeking employment
- O Unemployed, not seeking employment

Employment Arrangements - Exclude volunteering
- O Integrated (competitive) without supports
- O Integrated (competitive) with supports (e.g., Transitional employment, intensive supportive employment, ongoing supported employment)
- O Non-integrated (non-competitive)
- O Not employed

Average hours worked per week in the past month - Exclude volunteer work
- O At least 35 hours
- O 10 - 34 hours
- O 1 - 9 hours
- O None
- O Not employed

Compensation for work - Exclude volunteer work
- O At or above minimum wage
- O Below minimum wage
- O No pay
- O Not employed

Volunteers
Works as a volunteer (e.g., for community services) O No O Yes

Highest level of education completed
- O No schooling
- O 8th grade or less
- O 9-11 grades
- O High school or GED
- O Business or technical school
- O Some college, no degree
- O Associate's degree
- O Bachelor's degree
- O Graduate degree

Enrolled in formal education program
- O No
- O Part-time
- O Full-time

Risk of unemployment or disrupted education

Increase in lateness or absenteeism over LAST 6 MONTHS	O No O Yes O Not applicable
Poor productivity or disruptiveness at work or school	O No O Yes O Not applicable
Expresses intent to quit work or school	O No O Yes O Not applicable
Persistent unemployment or fluctuating work history over LAST 2 YEARS	O No O Yes O Not applicable

Person prefers change (when asked)

Paid employment (e.g., type, hours, pay)	O No O Yes O Could/would not respond
Employment support services (e.g., pre-vocational services, transitional employment, Intensive supported employment, ongoing supported employment)	O No O Yes O Could/would not respond
Education/training	O No O Yes O Could/would not respond
Educational support services	O No O Yes O Could/would not respond

Finances
Because of limited funds, during the LAST 30 DAYS made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care O No O Yes

Comments, Section P

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SECTION Q: ENVIRONMENTAL ASSESSMENT

Home Environment
Code for any of the following that make home environment hazardous or uninhabitable
(if temporarily in institution, base assessment on home visit)

Disrepair of the home (e.g., hazardous clutter; inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor; leaking pipes)	O No	O Yes	O Unknown, home not visited or no information
Squalid condition (e.g., extremely dirty, infestation by rats or bugs)	O No	O Yes	O Unknown, home not visited or no information
Inadequate heating or cooling (e.g., too hot in summer, too cold in winter)	O No	O Yes	O Unknown, home not visited or no information
Lack of personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)	O No	O Yes	O Unknown, home not visited or no information
Limited access to home or rooms in home (e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering, no rails although needed)	O No	O Yes	O Unknown, home not visited or no information

Comments, Section Q

SECTION R: DISEASE DIAGNOSES

DSM-IV Provisional Diagnostic Category
[Identify all provisional categories of DSM-IV diagnoses determined by the psychiatrist or attending physician and rank their importance as factors contributing to this admission
(if no provisional diagnosis available, mark all "No provisional diagnosis")

Codes:
0 = Not present
1 = Most important
2 = Second most important
3 = Third most important
4 = Less important
8 = No provisional diagnosis

	0	1	2	3	4	8
Disorders of childhood or adolescence	O	O	O	O	O	O
Delirium, dementia, and amnestic and other cognitive disorders	O	O	O	O	O	O
Mental disorders due to general medical conditions	O	O	O	O	O	O
Substance-related disorders	O	O	O	O	O	O
Schizophrenia and other psychotic disorders	O	O	O	O	O	O
Mood disorders	O	O	O	O	O	O
Anxiety disorders	O	O	O	O	O	O
Somatoform disorders	O	O	O	O	O	O
Factitious disorders	O	O	O	O	O	O
Dissociative disorders	O	O	O	O	O	O
Sexual and gender identity disorders	O	O	O	O	O	O
Eating disorders	O	O	O	O	O	O
Sleep disorders	O	O	O	O	O	O
Impulse-control disorders not elsewhere classified	O	O	O	O	O	O
Adjustment disorders	O	O	O	O	O	O
Personality disorders	O	O	O	O	O	O

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Psychiatric Diagnoses
(Mental Health and Substance Use Disorder)
Enter Axis I and Axis II DSM-IV diagnoses, if known. Must be completed on program discharge, but also complete with earlier assessments if specific psychiatric diagnosis already determined.

Axis I - DSM-IV code

_____

_____

Axis II - DSM-IV code

_____

Intellectual Disability
(e.g., Down Syndrome) O No O Yes

Medical Diagnoses

Disease code
0 = Not present
2 = Diagnosis present, receiving active treatment
3 = Diagnosis present, monitored but no active treatment

	0	2	3
Asthma	O	O	O
Diabetes mellitus	O	O	O
Hypothyroidism	O	O	O
Migraine	O	O	O
Traumatic brain injury	O	O	O
Heart disease	O	O	O
HIV/AIDS	O	O	O
Chronic Obstructive Pulmonary Disease (COPD)	O	O	O
Hypertension	O	O	O
High cholesterol or triglycerides	O	O	O
Tuberculosis (either active or newly confirmed inactive infection)	O	O	O
Hepatitis C	O	O	O

Other Medical Diagnoses (ICD-9/ICD-10 codes)

Disease code
0 = Not present
2 = Diagnosis present, receiving active treatment
3 = Diagnosis present, monitored but no active treatment

	Disease Code 0	2	3
_____	O	O	O
_____	O	O	O
_____	O	O	O
_____	O	O	O
_____	O	O	O
_____	O	O	O
_____	O	O	O

Comments, Section R

SECTION S: DISCHARGE

How long person is expected to receive services from this agency
(count from assessment reference date, including that day)

- O 1 to 7 days
- O 8 to 14 days
- O 15 to 30 days
- O 31 to 90 days
- O 91 or more days

Last day of involvement with program or agency ☐☐ / ☐☐ / ☐☐☐☐
Complete only at discharge

NEW YORK STATE
Office of Mental Health
Office of Alcoholism and Substance Abuse Services

Community Mental Health Assessment

Program Discharge/Transitioned To

- O Private home/apartment/rented room
- O DOH adult home
- O Homeless - shelter
- O Homeless - street
- O Mental Health supported/supportive housing (all types)
- O OASAS/SUD community residence
- O OCFS/ACS/DSS community residence program (Family foster care group home, Therapeutic foster care)
- O Unspecified/Other

  Describe:
- O OPWDD community residence
- O Long-term care facility (nursing home)
- O Rehabilitation hospital/unit
- O Hospice facility/palliative care unit
- O Acute care hospital/unit
- O Correctional facility
- O Deceased

SECTION T: ASSESSMENT INFORMATION

Assessment Notes Comment on additional information that is pertinent to this individual or contributors to the assessment process: