STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Health Home Learning Collaborative

Chart Review Workbook (CRW) Updates

April 23rd, 2024

This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid

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Agenda

- Introductions
- Chart Review Workbook…….....…Molina, ITC, Wellpoint, & HHS
- Survey Results……Molina, ITC, Wellpoint, & HHS
- Questions……...All

  - Coming Up
    - *May 20th, 2024 – Annual InterRAI Training*
    - *June 17th, 2024 – Comprehensive Assessment Process – CASH/LOCUS/CALOCUS*
    - *July 15th, 2024 – Risk Stratification*

Roles and Responsibilities

Please sit in the area designated for your position.

Roles and Responsibilities

- Director/Supervisor/Team Lead
- Care Coordinator
- Nurse Care Manager (RN)
- Trained Peer Support and/or Family Peer Support

Roles and Responsibilities: Core Services

- Director/Supervisor/Team Lead
  - Oversight of program and/or staff
- Care Coordinator
  - Care Coordination
  - Comprehensive Care Management
  - Transitional Care Management
  - Referral to Community and Social Support
  - Health Promotion
- Nurse Care Manager (RN)
  - Health Promotion
  - Transitional Care Management
  - Referral to Community and Social Support
  - Care Coordination
  - Comprehensive Care Management
- Peer Support and/or Family Peer Support
  - Individual and Family Support
  - Referral to Community and Social Support

Roles and Responsibilities: Core Services

Care Coordinator and/or Nurse Care Manager

- Successful outreach to engage the member in assessment or care plan.
- Initial and ongoing assessment
  - Completed within 30 days of enrollment
  - Completed within 365 days of previous assessment
  - ALL sections complete
  - In-person
- Care Plan
  - Assign team roles and responsibilities.
  - Completed within 30 days of assessment
  - Completed within 365 days of previous plan
  - ALL sections complete
  - In-person (unless addendum)
- Gap in care and predicted risks based on medical and behavioral claims data matched to the Standard of Care Guidelines.
  - Member has diabetes, anxiety and depression. Must use most current standards of care to identify what is need to manage those conditions as well as any prevention or risk needs.

Roles and Responsibilities: Care Coordinator with team support

- Assessment/Comprehensive Assessment and Social History (CASH)
  - Completed within 30 days of enrollment
  - Completed within 365 days of previous assessment
  - ALL sections complete
  - In person
- Person Centered Service Plan
  - Completed within 30 days of assessment
  - Completed within 365 days of previous plan
  - ALL sections complete
  - In person (unless addendum)
- Hab/CMH requirements
  - Monthly contact via call
  - Quarterly face to face in member home

Roles and Responsibilities: Activity

Share within your small group:

- **Within your health home, what part of the Assessment and PCSP completion are your responsibility?**
- **How do you know when to complete your part?**
- **What is the process to track these are done timely.**

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Roles and Responsibilities: Core Services

Care Coordinator and/or Nurse Care Manager

- Care Coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support, lifestyle modification, and behavior changes. The health home must work with providers to coordinate, direct, and ensure results are communicated back to the health home.
  - Implement the PCCP or PCSP
  - Successful outreach to coordinate care
  - Monitor with the member and collaterals progress towards goals
  - Addressing barriers to plan
  - Arrange for care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care
  - Hab/CMH requirements
    - Monthly contact via call
    - Quarterly face to face in member home

Roles and Responsibilities: Core Services

Care Coordinator

- Comprehensive Transitional care is the facilitation of services for the member that provides support when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community-based group home, family, self-care, or another health home)
  - Engage member in alternatives to ER or Hospital.
  - Follow-up phone calls and F2F visits after discharge.
  - Link to LTSS
  - Notify all providers and community support of admission, discharge or transfer.
  - Active in the discharge planning process, updating the assessment/plan if needed.
  - Medication reconciliation.
  - Support scheduling of follow-up appointments.

SPA: Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care

Roles and Responsibilities: Core Services

All Roles

- Referral to Community and Social support services includes coordinating or providing recovery services and social health services available in the community, including resources for understanding eligibility for various health care programs, disability benefits, and identifying housing programs.
  - Wellness programs, including tobacco cessation, fitness, nutrition or weight management programs, and exercise facilities or classes
  - Specialized support groups (i.e., cancer or diabetes support groups, NAMI psychoeducation)
  - School supports
  - Substance treatment links in addition to treatment -- supporting recovery with links to support groups, recovery coaches, and 12-step programs
  - Housing services Housing and Urban Development (HUD), rental assistance program through the Iowa Finance authority
  - Food Assistance Iowa Department of Human Services (DHS), Food Bank of Iowa
  - Iowa Department of Public Health (IDPH) Programs
  - Transportation services (NEMT), free or low-cost public transportation
  - Programs that assist members in their social integration and social skill building
  - Faith-based organizations
  - Employment and educational programs or training, Iowa Workforce Development(IWD), Iowa Vocational Rehab Services (IVRS)
  - Volunteer opportunities
  - Monitor and follow-up with referral source, member, and member's support to ensure that members are engaged with the service

Roles and Responsibilities: Core Services

Care Coordinator and Nurse Care Manager

- Health Promotion includes the education and engagement of a member in making decisions that promote health management, improved disease outcomes, disease prevention, safety, and an overall healthy lifestyle.
  - Assist members in managing their health through motivational interviewing, trauma informed care, and other evidenced-based practices.
  - Self-management plans and relapse prevention plans.
  - Self-direction and skill development with managing medications.
  - Prevention Education.

*** Trained Peer and Family Peer can complete WRAP plan.

Roles and Responsibilities: Core Services

Peer Support & Family Peer Support

- Individual and family support services include communication with the member and the member's family and caregivers to maintain and promote quality of life, with particular focus on community living options. Support will be provided in a culturally appropriate manner.
    - The Peer/Family Peer provides support to the member based on lived experience and training

Roles and Responsibilities:

Activity- Who does this within your IHH?

- HCBS Residential Settings Assessments
  - Annually
    - Via IMPA portal
- Risk Stratification
  - Annually
    - Via IHH identified tool
- Authorizations/NODs
  - At least annual and as services change
- Critical Incident Report PCSP Addendum
  - Each time a CIR is filed for member
  - Via IMPA portal

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Roles and Responsibilities:

Activity- Who does this within your IHH?

- Health Risk Screener
  - Annually
    - Via portal or Member services
- Chronic Conditions
  - According to diagnoses and member need
    - Education
    - Medication management
    - Appointments and following provider recommendations
- Provider Contacts
  - According to diagnoses and member need
- Contact Notes
  - Each time a member or provider is spoken too
  - Each time something is done on behalf of the member

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Chart Review Workbook (CRW) Changes

Timeline Changes

- Moving from quarterly to monthly reviews
- Groups 1-4
- 3-4 IHHs reviewed per month

Chart Review Group	Subcategory
Group 1 - April	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 1 - May	Request charts from Health Homes
	Review charts for review
	Provide feedback to Health Homes
Group 1 - June	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 2 - July	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 2 - August	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 2 - September	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 3 - October	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 3 - November	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 3 - December	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 4 - January	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 4 - February	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes
Group 4 - March	Request charts from Health Homes
	Review charts for review period
	Provide feedback to Health Homes

NEW

Category	Subcategory
Chart Reviews	
Grp 1	Request charts from Health Homes for review period October 1, 2020 - Sept 30, 2021
	Review charts for review period October 1, 2020 - Sept 30, 2021
	Review results with IME / MCOs for review period October 1, 2020 - Sept 30, 2021
	Provide feedback to Health Homes for review period October 1, 2020 - Sept 30, 2021
Grp 2	Request charts from Health Homes for review period January 1, 2021 - December 31, 2021
	Review charts for review period January 1, 2021 - December 31, 2021
	Review results with IME / MCOs for review period January 1, 2021 - December 31, 2021
	Provide feedback to Health Homes for review period January 1, 2021 - December 31, 2021
Grp 3	Request charts from Health Homes for review period April 1, 2021 - March 31, 2022
	Review charts for review period April 1, 2021 - March 31, 2022
	Review results with IME / MCOs for review period April 1, 2021 - March 31, 2022
	Provide feedback to Health Homes for review period April 1, 2021 - March 31, 2022
Grp 4	Request charts from Health Homes for review period July 1, 2021 to June 30, 2022
	Review charts for review period July 1, 2021 to June 30, 2022
	Review results with IME / MCOs for review period July 1, 2021 to June 30, 2022
	Provide feedback to Health Homes for review period July 1, 2021 to June 30, 2022

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Survey Q&A

- Question: Will each IHH remain in their previously assigned Chart Review Workbook Groups?
  - Answer: Yes, group assignments have not been changed

- Question: Why are there so many standards for a voluntary service? This makes it difficult for IHHs to be successful.
  - Answer: Regulations and standards are in place to support the program to meet the needs of the ICM and non ICM population. ICM members specifically fall under the Targeted Case Management population which includes additional mandates and requirements under Iowa code. MCOs and HHS work to support IHHs and our members to administer the program to align with code and member needs.

Workbook Results & Feedback Process (In-Progress)

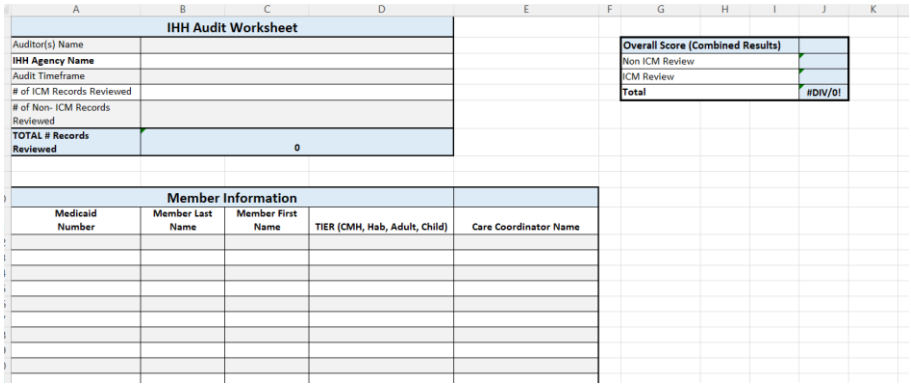
- MCOs/HHS utilized feedback from IHHs to reform the results and feedback process for a more unified and strategic approach
- Updated process is intended to fully support Health Homes in process improvement initiatives and maintain joint communication amongst entities
- Ongoing support and communication built into new feedback and review process
- Each Health Home will have an assigned MCO to support them throughout review process
  - Any questions or concerns about the CRW process of MCO assignment can be directed to assigned MCO

Workbook Results & Feedback Process (In-Progress)

- Each MCO/HHS's Workbook results will be shared with QIO team who will then combine feedback to send one document to each Health Home
- A joint meeting will take place so results can be discussed
- As needed, Health Homes will complete an Action Plan to address improvement needs and send to assigned MCO
- Action Plan will be reviewed by all MCOs and HHS collaboratively
- Within 30 days and routinely after as needed, MCOs will meet with Health Home to support implementation of Action Plan
- Progress will be monitored, documented, and shared amongst MCOs and HHS

CRW Tab Changes

- Timeline: updated to match new process
- Demographics: reformatted based on IHH feedback
- Non-ICM Review, and ICM Review: reviewed by all entities to ensure compliance with state and federal regulations



IHH Audit Worksheet	
Auditor(s) Name	
IHH Agency Name	
Audit Timeframe	
# of ICM Records Reviewed	
# of Non- ICM Records Reviewed	
TOTAL # Records Reviewed	0

Overall Score (Combined Results)	
Non ICM Review	
ICM Review	
Total	#DIV/0!

Member Information				
Medicaid Number	Member Last Name	Member First Name	TIER (CMH, Hab, Adult, Child)	Care Coordinator Name

PREVIOUS

2024-2025 IHH Audit Worksheet	
Auditor(s) Name/MCO	
IHH Agency Name	
IHH Contact	
Audit Group	
Audit Timeframe	
# of Non-ICM Records Reviewed	
# of ICM Records Reviewed	
TOTAL # Records Reviewed	0

Rating	
Non ICM Review	add formula
ICM Review	add formula
Overall Score	add formula
Expected Score	94%

Member Information			
Medicaid Number	Member Last Name	Member First Name	TIER (CMH, Hab, Adult, Child)

NEW

CRW Tab Changes

- NEW: Non-ICM Guide, and ICM Review Guide
  - Added to include where the requirements or basis for each standard can be located (i.e. SPA, IAC, IHH Provider Manual, etc.)
  - Intended to promote transparency amongst IHHs, MCOs, and HHS, along with increased access to resources and written regulations
  - Allows for better use of the CRW as a guide for IHHs as they review/revise policies, procedures, and trainings

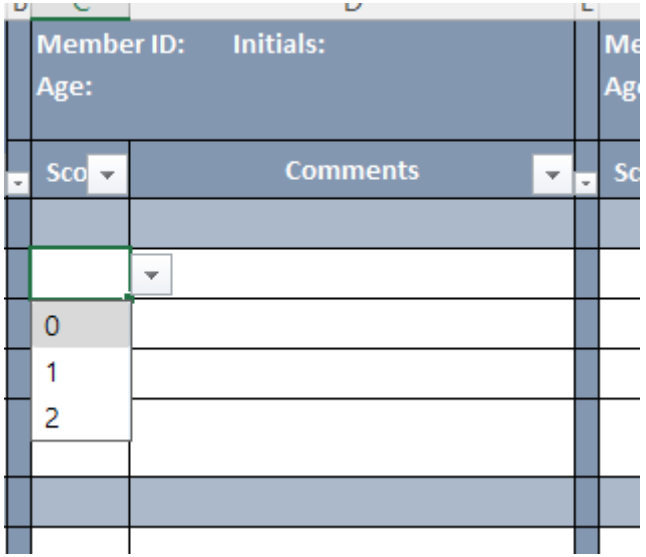
Format

- Order of standards aligns with flow of annual documents
  - CASH & PCSP
    - Flow of these documents more closely matches the flow of the CRW
    - Creates better ease of use for both IHHs and reviewers
- Headers and clusters of standards are more organized and strategically grouped

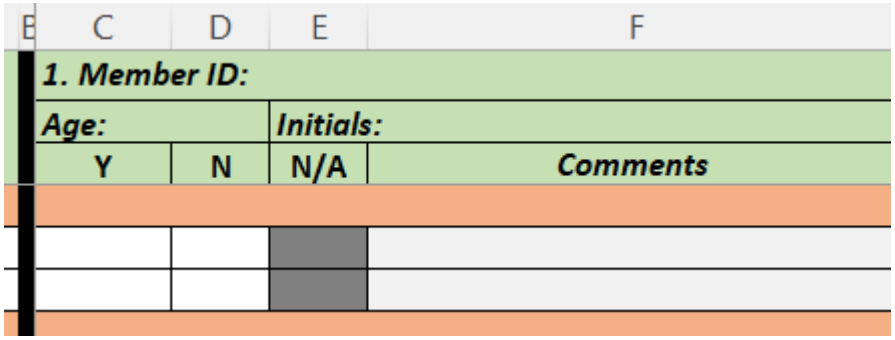
0	**Comprehensive Assessment & Social History & InterRAI**
1	A Comprehensive Assessment & Social History has been completed within 30 days of enrollment or an updated Comprehensive Assessment & Social History has been completed within the review period.
2	Current InterRAI is present in the member's record. (Child's Mental Health Waiver).
3	**Communication & Language**
4	Comprehensive Assessment & Social History documents specific needs to consider in the person-centered service plan regarding effective communication for visual and hearing impairment and need for or use of devices.
5	Comprehensive Assessment & Social History includes status of cognitive functioning including the member's ability to communicate and understand instructions and the member's ability to process information about an illness.
6	Special communication or cultural needs are assessed / documented in the record including an assessment of the member's culture and language needs and their impact on communication, care, or acceptability of specific treatments.
7	**Social**
8	Comprehensive Assessment & Social History includes information on social functioning and its effect on the member's mental and physical health including the member's engagement with friends and family, social isolation, and employment status.
9	Comprehensive Assessment & Social History includes information about a member's health beliefs and behaviors.
0	**Medical & Mental Health**
1	Comprehensive Assessment & Social History includes information on presence or absence of physical and mental health conditions and their status.
2	Comprehensive Assessment & Social History contains information on the member's clinical history including past hospitalizations and major procedures, including surgery (dates must be included), significant past illnesses and treatment history, past medications tried, and toxin exposure.

Scoring Changes

- Overall calculation remains the same
- Y, N, N/A columns removed
- 0, 1, 2 dropdown function added
  - 0 = N/A
  - 1 = Does Not Meet
  - 2 = Meets



NEW



PREVIOUS

Survey Q&A

- Question: How will the new scoring work, and will this be manually calculated?
  - Answer: In the new scoring 0 = standard is not applicable, 1 = the standard was not met, 2 = the standard was met. Formulas are built into the workbook to calculate totals.

- Question: How will inconsistent results between MCOs and HHS be avoided?
  - Answer: MCOs and HHS use the same chart review workbook tool to review members within their respective assignments, and results will be discussed amongst MCOs and HHS prior to a comprehensive result document being shared with IHHs. The overall scores will be an average between all reviewing entities and their review results. Scores may vary based on individual charts reviewed and differences will be examined and reviewed between entries, but total alignment of scores cannot be guaranteed due to variation in records.

Questions?

Standard Changes, Updates, and Clarification

Chart Overview – Non ICM & ICM

Standard	Type of Change	Clarification
Each page of member's record contain member's first and last names when viewing on electronic health record. When documents are printed from electronic health record must also include medical assistance number and date of birth.	Standard Update and Clarification Update	If electronic health record (EHR) access, member first and last name must be on each screen/page. If reviewing EHR, need to print screen to PDF to verify the functionality of this within EHR to also include the medical assistance identification number and date of birth. can print to PDF to verify the functionality. If record includes information/documents for the wrong member select 1 (does not meet). Health Risk Assessment (HRS), InterRAI, Home & Community Based Services (HCBS) Residential Assessment & Critical Incident Report (CIR) are standardized forms by State, Managed Care Organizations or specific company these would be excluded as health home is not able to add to header/footers, these documents are not used to mark out of compliance. If these are the only documents without identifiers select 2 (meets). Fax cover sheets completed by health home need to include a member identifiers, if it does select 2 (meets).

Standard	Type of Change	Clarification
Wellpoint Only: A Health Information Portal (HIP) form been completed on Availity in the review period for the member.	Clarification Update	Health Information Portal (HIP) should be updated in Member360 at some point during review period. Iowa Medicaid, Iowa Total Care & Molina select 0 (not applicable). If Iowa Medicaid sees this in their records they will select 1 (does not meets). This standard is not figured in overall score.

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Enrollment Eligibility – Non ICM & ICM

Standard	Type of Change	Clarification
Member consent for health home enrollment is documented in the chart.	Clarification Update	This is not required to be updated annually. This may be completed outside of the review period. Informed consent must list health home as part of the services and meet the requirements. Cannot be a document outlining all services that the agency provides. Can be a contact note outlining the steps taken with the member to enroll in the health home and that they agreed to enroll and member can verbally consent. Consent identified in care plan does not meet this standard, if this is the only place select 1 (does not meet). If missing, recoupment for entire review period could occur, as documented consent is required for enrollment select 1 (does not meet). **Consent Requirements:** - Member Agrees to opt-in to health home services and opt-out at any time - Health explained or reviewed the role and responsibilities of the health home - Health home works as a team with the member at the center to improve the member's care - How member presented to the health home, including the referral - Identified needs and plan to assess for eligibility - Documentation that member is eligible for health home service, if not eligible health must document the plan to support the member. - Qualifying diagnosis - Member agreement and understanding of the program. - Enrollment request. - Enrollment with the health home. - Plan to complete the comprehensive assessment. - Documentation of continued eligibility, reviewed annually and maintained in the member's service record

Diagnosis & Functional Impairment – Non ICM

Standard	Type of Change	Clarification
Record contains documentation of members diagnosis & functional impairment completed by a mental health professional within the review period. 	Clarification Update	Diagnosis and functional impairment needs to be updated annually and signed by a Licensed Mental Health Professional (LMHP). Therapy Office Visit Notes may count if the notes clearly identify function impairment documentation along with diagnosis, has a date of visit and is signed select 2 (meets). If it is just a summary of the visit select 1 (does not meet). Health home may have their own functional impairment form. Electronic health record (EHR) if they have a diagnosis tab and is updated and noted by licensed mental health professional select 2 (meets), as long functional impairment is also updated. Need to make sure qualified mental health provider- cannot be documentation from emergency department physician. Both diagnosis and functional impairment need to be current within review period and completed by a Licensed Mental Health Professional to select 2 (meets). If any comment is missing select 1 (does not meet). If health home developed a diagnosis and function impairment document and LMPH filed out the document, signed and dated the document annually select 2 (meets). If diagnosis and fictional impairment is provided by LMHP from a hospitalization and is dates and signed select 2 (meets).

Diagnosis & Functional Impairment - ICM

Standard	Type of Change	Clarification
Record contains documentation of members diagnosis & functional impairment completed by a mental health professional within the review period.	Clarification Update	**This standard is scored and looked at differently than non-ICM members for enrollment & renewal, at this time.** If member is approved for habilitation, members comprehensive assessment and social history (CASH) and LOCUS/CALOCUS is current during review period select 2 (meets). If not current, select 1 (does not meet). The CASH and LOCUS/CALOCUS is used as diagnosis and functional impairment verification. If member is approved for Children's Mental Health (CMH) Waiver members diagnosis must be completed by a License Mental Health Professional (LMHP), the document must **note the date of last visit** (the LMPH just signing and dating the document is not sufficient) and has to be within 365 days of the assessment completed dated and if interRAI CMH is current during review period, if all are identified select 2 (meets).

Per Member Per Month (PMPM)

Monthly Per Member Per Month (PMPM) Non-ICM & ICM

Standard	Type of Change	Clarification
At least one core health home service was provided for each claim submitted during the review period.	Clarification Update	At least **one health home core service** needs to be provided: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transition of Care, Individual and Family Support and/or Referral to Community and Social Support Services. Notes identify health home core service and demonstrate monitoring & following of activities that ensures the health, safety and welfare of the member, follow-up and monitoring of all services regardless of the service funding stream, including those service member has declined. If there are no claims and no notes for entire review period select 0 (not applicable). A comment will be made to follow unable to reach policy and disenrollment of member is needed. If there has been a claim submitted and there is no documentation for that month or the documentation does not support a core service was provided in the member's record select 1 (does not meet). If billable note for the month only includes a text to the member and there is no reply back that supports a core service select 1 (does not meet). If billable note for the month is only a letter and does not show coordination of service efforts select 1 (does not meet). If billable note says monitored for care gaps and does not identify what actual care gaps were looked for and does not include follow-up steps select 1 (does not meet). If billable note is the same (identical) month after month select 1 (does not meet).

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Per Member Per Month - Core Service Activity

- What are billable activities you do in your role/health home to support the Per Member Per Month (PMPM)?

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transition of Care
- Individual and Family Support and/or
- Referral to Community and Social Support

Monthly Per Member Per Month (PMPM) Non-ICM & ICM

Standard	Type of Change	Clarification
At least one core health home service was provided for each claim submitted during the review period.	Clarification Update	At least **one health home core service** needs to be provided: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transition of Care, Individual and Family Support and/or Referral to Community and Social Support Services. Notes identify health home core service and demonstrate monitoring & following of activities that ensures the health, safety and welfare of the member, follow-up and monitoring of all services regardless of the service funding stream, including those service member has declined. If there are no claims and no notes for entire review period select 0 (not applicable). A comment will be made to follow unable to reach policy and disenrollment of member is needed. If there has been a claim submitted and there is no documentation for that month or the documentation does not support a core service was provided in the member's record select 1 (does not meet). If billable note for the month only includes a text to the member and there is no reply back that supports a core service select 1 (does not meet). If billable note for the month is only a letter and does not show coordination of service efforts select 1 (does not meet). If billable note says monitored for care gaps and does not identify what actual care gaps were looked for and does not include follow-up steps select 1 (does not meet). If billable note is the same (identical) month after month select 1 (does not meet).

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Monthly Per Member Per Month (PMPM) - ICM

Standard	Type of Change	Clarification
There is documentation that the member or legal representative was contacted by the care coordinator/nurse monthly, either in person or by phone  	Standard Update Clarification Update	Can be with legal representative for both Children's Mental Health waiver or Habilitation. If only email or text is used to contact the member/legal representative select 1 (does not meet). If only one attempt to reach the member was made select 1 (does not meet). If no monthly contact was made with member/legal representative but notes indicate multiple attempts and method(s) to reach member/legal representative select 2 (meets). If only contact is completed by the nurse or Family Peer Support or Peer Support select 1 (does not meet). If notes are not entered timely, request policy and procedure for entering in contact notes, if meets their identified guidelines, select 2 (meets). If no policy and procedure was provided or documentation entry timeline was not followed or identified select 1 (does not meet). Notes reflect monitoring & following of activities that ensures the health, safety and welfare of the member or demonstrate follow-up and monitoring of all services regardless of the service funding stream or demonstrate follow-up and monitoring of services the member has declined in the service plan select 2 (meets). **PMPM must be member centered-whole person.** **Timely entry of notes into the electronic health record. Must be entered before billing.**

Monthly Per Member Per Month (PMPM) - ICM

Standard	Type of Change	Clarification
There is documentation that the member was visited in their residence by the care coordinator/nurse at least quarterly.	Standard Update Clarification Update	Must be completed in the home with the member. If only with legal representee select 1 (does not meet). If only one attempt is noted select 1 (does not meet). If meeting somewhere else due to illness of someone living in the home, bed bugs, etc., the reason for not meeting in the home must be documented clearly in that note and education was provided regarding need to meet in home to receive Children's Mental Health Wavier or Habilitation if note identifies this select 2 (meets). Part of case management is assessing the living environment on an ongoing basis. If member is requesting not to have in person home visits, this needs to be well documented on why not and how the health home is working towards visits in the home such as assessing health, safety, welfare and expectation of the program. If member refuses quarterly home visit, a goal needs be written into plan to showing how the health home will work with the member on working towards visits to occur in the home. If no goal in place select 1 (does not meet). If note states met member "in front of home" need clear documentation on why and if member refuses to let in this must be documented and education was provided, select 2 (meets).

Health Home should have a policy/procedure that outlines expectations on timeliness of entering in contact notes and be entered prior to billing for the service.

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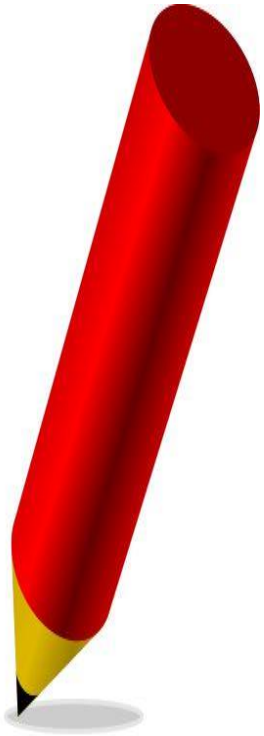
Activity: Core Service & Billable



- Is this a Core Service Activity?
- If so, is it billable?
- If not, how do you make it billable what activity and documentation is need?
  - Completed the care plan with the member
  - Reviewing file and MCO portals for care gaps
  - Completed Risk Stratification Tool without member
  - Leaving voicemail, sending a test or email
  - Mailing/emailing flyer or newsletter
  - Contacting legal representative for monthly visit/quarterly visit
  - Receiving a phone call/email from Provider

Completed the care plan with the member

- Core Service: Yes
- Billable: Yes

Reviewing file and MCO portals for care gaps

- Core Service: Possibly
- Billable: No, just looking for and identifying care gaps in the portal by itself is not billable or a core service
- How to make billable?
  - Why was a care gap looked for identified?
  - Where did was the care gap identified at?
  - What actual care gap was identified?
  - What did/is the HH doing to help close that gap?
    - Contact the member to discuss the identified care gaps
    - Contact the provider to see why the member has not been attending
  - Document the care gaps and how you closed those gaps or offered support to close those care gaps.

- Key when a care gap is identified to make it billable you MUST take the next step to address that closure of the care gap by talking with the member to determine what support/assistance they need in closing that gap.

Completed Risk Stratification Tool without member

- Core Service: Yes
- Billable: No
- How to make this billable?
  - Need to complete the risk stratification with the member.
  - Document the contact that you completed with member via phone or in person to complete the risk start

- Note: Risk stratification that have members showing as Children's Mental Health Waiver or Habilitation that they are automatically – high risk will be out of compliance. This is a service a member receives and the support they get should help decrease the need. Identify what things you are looking for to identify low, medium, high risk.

Leaving a voicemail or sending text/email

- Core Service: No
- Billable: No
- What we see? One or multiple outreaches without identifying what you are contacting them for
- How to make this billable?
  - Need to have an exchange of contact with the member/provider regarding goals or reason you are reaching out.
  - More than one attempt a month should be attempted and different times during the month on different days.
  - It is important to document your attempts as it shows the work that you are trying to engage the member.

Mailing Flyers or newsletters

- Core Service: No
- Billable: No
- How to make this billable?
  - Need to show the exchange of information you have with the member that is specific to their need i.e.
    - Food pantry – did they report they are food scarce?
    - Coat drives – did they report they are worried about getting clothing?
    - Support Groups – are the support groups specific to the members identify needs, diagnosis, etc.
    - Flu Shot/Vaccinations – is the member not getting these? Do they have a reason they are not getting them.
    - Diabetic Support Groups – does the member have diabetes? Is it uncontrolled?
- These could be useful as talking points when meeting with members to provide additional information on what is available when the need is identified. Make to document dialogue regarding the need and provided additional newsletter/flyer for reference later.
- The conversation about the mailer/flyer is what is billable not providing them the mailer/flyer.

Contacting Legal Representative Monthly

- Core Service: Yes
- Billable: Yes
- Iowa Code Chapter 90 Rules
  - Contact to be with member and/or legal representative.
  - Quarterly Face Visit - needs to done in the member's home; member must be present
  - Month Contact – with member. If a minor, can be with legal representative, however, be mindful of child's age and the value of getting their feedback, desires, wishes, thoughts and their future plans. Adults with legal representative should communicate with them regarding goals, updates from member and providers.
- Contact must be meaningful, person-centered and whole person. Should not see "reached out for my monthly update" This is not about the Health Home getting an update but about what the Health Home is doing to support the member.

Receiving Voicemail or Email from Provider

- Core Service: Possibly
- Billable: No
- How to make billable?
  - Reach out to provider/member/legal representative to follow-up on the information provider and look for gaps that need to be followed-up on.

Service Utilization

Service Utilization - ICM

Standard	Type of Change	Clarification
The record contains documentation that the care coordinator reviewed utilization for waiver/habilitation services identified in the person-centered service plan at least quarterly.	Standard Update Clarification Update	At least quarterly, contact notes identify that the care coordinator is talking with member/legal representative/provider regarding their services and frequency they are receiving the service and verifying that service usage aligns with services in person-centered service plan. Contact notes identify that care coordinator used Managed Care Organizations (MCO) portals for claims information on utilization and that it aligns with services in the person-centered service plan. Reviewers will review the MCO claims utilization to verify utilization billed per each service to verify if there is discrepancy between what was requested and what was utilized, if discrepancy and care coordinator notes do not include discussion select 1 (does not meet).

Service Utilization - ICM

Standard	Type of Change	Clarification
If the member is receiving less services than indicated in the person-centered service plan, this was addressed by the team.	Clarification Update	If member is utilizing services as identified in person-centered service plan, select 2 (meets). If member is not utilizing services as indicated in the plan, look for documentation that addresses rationale for discrepancy between authorized services and services being provided/utilized, if identified, select 2 (meets). As long as care coordinator talked with member/legal representative or provider and identified why not utilizing the service select 2 (meets). If reason for not using services is situational and explained by the member e.g. busy with summer activities, hospitalization, other obligations, etc. select 2 (meets).

Service Utilization - ICM

Standard	Type of Change	Clarification
If the member is receiving less services than indicated in the person-centered service plan, this was addressed by the team.	Clarification Update	If member is utilizing services as identified in person-centered service plan, select 2 (meets). If member is not utilizing services as indicated in the plan, look for documentation that addresses rationale for discrepancy between authorized services and services being provided/utilized, if identified, select 2 (meets). As long as care coordinator talked with member/legal representative or provider and identified why not utilizing the service select 2 (meets). If reason for not using services is situational and explained by the member e.g. busy with summer activities, hospitalization, other obligations, etc. select 2 (meets).

Service Utilization - ICM

Standard	Type of Change	Clarification
Documentation indicated that care coordinator reviewed service provider documentation to ensure the person-centered service plan is effectively implemented and adequately addresses the needs of the member quarterly.	Standard Update Clarification Update	Contact notes indicate that documentation was reviewed or requested from provider at least quarterly select 2 (meets). If member is receiving more than one service, must review records for each provider/service. This is not a report from the provider on how services were going. This is reviewing actual services notes and summary/findings of the review. This is done in the provider office unless the provider is okay with submitting documentation electronically or by email. If the contact notes show ongoing outreach to provider (quarterly) to schedule a review of documentation but provider did not provide select 2 (meets).

Comprehensive Assessment

Assessment - Non ICM

Standard	Type of Change	Clarification
Comprehensive Assessment & Social History has been completed with the member in person within 30 days of enrollment or updated within the review period.	Standard Update Clarification Update	Assessment must be completed within 30 days of enrollment and annually thereafter in person with the member/legal representative. If member is enrolled during review period, can base 30-day timeframe on date in contact notes indicating that the member agreed to enroll or date on the health home notification form. If not signed by member/legal representative or current during the review period, the entire section would be select 1 (does not meet). If not completed with the member/legal representative in person select 1 (does not meet). This needs to be signed by the staff person who met with the member to complete the assessment, the nurse or care coordinator, is responsible for this. If signed by member or nurse, this is a valid assessment. If not signed select 1 (does not meet). All roles should have input/information for the assessment, and this should be documented in the members record regarding the input they provided. This is a time when the nurse can provide medication reconciliation. If an assessment is completed, even if it is not comprehensive or if some questions in the assessment are left blank select 2 (meets). Continuity of Care document is not a comprehensive assessment history.

Any work done in advanced of the meeting to gather information must be documented in real time in the member's record.

Assessment - Non ICM

Standard	Type of Change	Clarification
The comprehensive assessment address wellness, education, employment, substance use, housing, transportation, mental health, physical health, dental, and spiritual needs.	Clarification Update	If assessment was not completed during the review period, select 1 (does not meet). All areas need addressed if not select 1 (does not meet).
The assessment includes a current list of medications with dosages and schedules, including over-the-counter medications, herbal therapies, and supplements.	Clarification Update	If medication section is blank in the assessment select 1 (does not meet). If assessment says "see attached list" the list must be attached with the assessment. If the EHR has a medication screen and able to see date updated and within review period, select 2 (meets). Med list can be provided by health home or by provider. If contact notes indicate that a med change has been made but med list is dated prior to change, select 1 (does not meet). Assessment needs to indicate that member was asked if they are using over the counter (OTC) medications/supplements. If member reports not taking any medications and there is acknowledgement that there are no medications, select 2 (meets).

Reminder the nurse is responsible for medication reconciliation, assessing for understanding of medications, barriers to taking medications and any risks identified regarding medications.

Assessment - Non ICM

Standard	Type of Change	Clarification
Appropriate screenings have been administered as identified in the comprehensive assessment.	Clarification Update	Examples of screenings can include 3 question AUDIT, DAST, CAGE, CRAFFT, etc. Screeners that would indicate risk for member i.e. tobacco which kind, how much, etc. Mental Health screeners (depression/anxiety), substance abuse, etc. if these screenings indicate risk, it should be addressed in person-centered care plan or care coordination note. If member smokes but it is not addressed in the record, select 1 (does not meet). If assessment indicates that further exploration/information should be gathered, they should have additional screener or have addressed this. If member is already being treated for depression or substance abuse, a screener is not necessary, select 0 (not applicable). The screeners do not need to have a score, some may say positive/negative instead of a score. Some of the screeners are built into the assessment and if completed select 2 (meets). If using Comprehensive Assessment and Social History (CASH) the depression, alcohol, substance and gambling screenings are all included within the assessment and if completed select 2 (meets).

Comprehensive Assessment & Social History General Requirements - ICM

Standard	Type of Change	Clarification
Comprehensive Assessment & Social History has been completed with the member in person within 30 days of enrollment or updated within the review period.	Standard Update Clarification Update	If comprehensive assessment and social history (CASH) was completed within 30 days of enrollment or updated during the review period, even if some questions in CASH were left blank or if assessment was completed with 365 days of that last CASH in person meeting date select 2 (meets). Nurse (RN) or Care Coordinator (CC) must complete the CASH with member to be valid, if not completed by RN or CC, the rest of the CASH section would be marked 1 (does not meet). If the CASH completed outside of review period, a valid exception must be documented, if valid exception mark 2 (meets) and score remaining CASH standards. If not valid exception score 1 (does not meet) and remaining CASH standards will be scored 1 (does not meet) as there is not a current/valid assessment. Transfer between health homes: 30 days within enrollment does not apply to members that have transferred to a new IHH. For transfer members, if health home decides to use the previous health homes CASH, and sections are incomplete the new health home will be scored on that assessment unless they update one. If member is enrolled during review period, can base 30 day timeframe on date in contact notes indicating that the member agreed to enroll or date the health home identifies that member's enrollment has been approved. If assessment was not completed in person with the member and there is no Primary Care Physician (PCP) note attached to assessment identifying a medical reason for it to be completed telephonically select 1 (does not meet). Valid exceptions include: schedule conflicts, member in hospital or facility, member refused, waiver closed Income Maintenance notified, member no longer wants services, member deceased, other CASH can be built into health home electronic health record (EHR), but it must be built into the EHR in the same order as the approved template, if not select 1 (does not meet).

IOWA HHS

Comprehensive Assessment & Social History Identified Risks & Needs by Assessor - ICM

Identified Risk & Needs by the assessor, if anything other than "member has no needs in this area" for each identified area, additional information is required to identify support/services needed.

What is the assessor input regarding members supports and needs to remain safe and healthy.

Person-Centered Service Plan Standard Changes

General Requirements - ICM

Standard	Type of Change	Clarification
Person-centered service plan has been completed within the review period.	Standard Update Clarification Update	Person-centered service plan (PCSP) has to be valid in order for entire section to be scored. If not valid, entire section would be marked 1 (does not meet). A valid PCSP is completed timely (within 365 days of the last PCSP team meeting date), completed & signed by Nurse or Care Coordinator and includes member/legal representative signature. An intern can complete the CASH, as long as the RN or CC provide supervision during the meeting. If PCSP is not completed during the review period select 1 (does not meet). Valid exceptions include: schedule conflicts, member in hospital or facility, member refused, waiver closed Income Maintenance notified, member no longer wants services, member deceased, other. Pam to get timeframe for expectation to be scored. When PCSP falls outside of auditing period, but assessment occurs during review period, the PCSP to be reviewed is the one that occurs after the review period. The PCSP The Care Coordinator or Nurse must complete the PCSP with the member. The person who completes the PCSP with the member in person must sign the document.

General Requirement – Non ICM

Standard	Type of Change	Clarification
Person-centered service plan has been completed within the review period.	Standard Update Clarification Update	Care plan is completed during the review period select 2 (meets). If not updated during review period, select 1 (does not meet) along with all remaining standards in this section. The licensed health care professional must complete the care plan with the member/legal guardian, if not a licensed professional select 1 (does not meet). The nurse can review and sign off. Nurse, Licensed Social Worker or Licensed Master Social Worker are approved to complete the care plan, if one of these completes select 2 (meets). If Care Coordinator is no not licensed can provide input and sign plan. If not licensed complete the care plan, select 1 (does not meet) and score remaining section as 1 (does not meet). The PSS can provide input and sign the care plan. If they complete the care plan this select 1 (does not meet) and score remaining section as 1 (does not meet).
The person-centered care plan has been reviewed and revised at least every 365 days, or when there is a significant change in the member's condition or requested by the member.	Clarification Update	Must be updated within review period. If not updated or valid during review period, select 1 (does not meet). If significant change in level of care, frequent ER/hospital utilization, etc. an updated care plan must be completed to support the members needs. Must be completed in person with the member to select 2 (meets). If not completed by nurse or licensed care coordinator select 1 (does not meet).

General Requirements - ICM

Standard	Type of Change	Clarification
Person-centered service plan has been reviewed at least every 365 days.	Standard Update	Must be updated within review period. Person-centered service plan (PCSP) must be completed within 365 days of the last scheduled one. Example PCSP was held on 3/2/2021, next one is due on or before 3/2/2022. If health home has documented a exception or attempted outreach on or prior to the due date select 2 (meets). Valid exceptions include: schedule conflicts, member in hospital or facility, member refused, waiver closed Income Maintenance notified, member no longer wants services, member deceased, other.
Person-centered service plan was updated/revised when a significant change in members circumstances, member's condition or when changes were requested by the member/legal guardian.	Standard Update Clarification Update	Example: lengthy hospitalization, new life-altering diagnosis, change in services/provider, right restrictions/goal update, new risk identified, transferring IHHs, etc. If initial person-centered service plan (PCSP) and no significant change occurred select 0 (not applicable).

These two measures were in one, we have not separated them into two.

Preferences – Non ICM

Standard	Type of Change	Clarification
The person-centered care plan reflects the member / legal representative's preferences	Clarification Update	Preferences should address all the following items: inclination towards lifestyle, living situation and how care is to be provided, where/whom to live with, when to go to bed, when and what to eat, whom to involve in care planning, and which services and service providers to use If an item is not included or states member has no identified preferences in these areas select 1 (does not meet). If care plan indicates "none" or "no preferences" select 2 (meets). Make comment that health home should specifically document that member does not have preferences regarding these items. If care plan indicates NA or is blank select 1 (does not meet). If not completed by nurse or licensed care coordinator select 1 (does not meet).

Section 4: My Goals - ICM

Combined standards that were previously individual (old workbook #84 & 86)

Standard	Type of Change	Clarification
Person-centered service plan identifies a waiver or habilitation service there is a goal that is specific to the skills training and/or assistance to be provided for the amount and frequency identified.	Standard Update Clarification update	Location: * Section 4: Goals and * Section 5: My Services and Supports All habilitation and waiver service must have at least 1 identified goal per each service. Goals must support the frequency and amount of units identified Section 5 My waiver and habilitation supports. If there is a goal for each service select 2 (meets).

Non-ICM Goals

Standard	Type of Change	Clarification
The person-centered care plan includes individually identified goals.	Clarification	Should use person-first language. If goals are the same for all members and do not have any individualized information specific to the member select 1 (does not meet). Health Home must be identified in the incremental steps on how they will support and/or monitor the goals or assist the member with meeting their identified goals, if health home is not identified select 1 (does not meet). Member must have goal related to their health condition/diagnosis or functional impairment that they are enrolled in the health home for to help decrease the functional impairment. Member must determine and agree to the goals. **Goals must be updated yearly. If the same goal is in place each year the documentation must reflect what the barriers or why the goal remains in place if don't see documentation select 1 (does not meet).** If not completed by nurse or licensed care coordinator select 1 (does not meet).
The goals are observable, measurable, and timebound.	Clarification	Goals must be written in SMART goal format. Goal(s) has/have to meet all areas otherwise select 1 (does not meet). The objective statement, can be used to make the goal measurable vs. the actual goal statement. Incremental steps (action steps) must be incremental and support the goal/objective statement. If not completed by nurse or licensed care coordinator select 1 (does not meet).

Section 5: My Services & Supports
* My Discharge for Services - ICM

Standard	Type of Change	Clarification
Person-centered service plan includes a discharge plan that is specific to each Medicaid service the member receives.		Each waiver/habilitation service must have it's own discharge plan including 99490 and needs to be specific to the members needs. The discharge should not be the same discharge plan copied and pasted. Discharge plan should include what the member needs to accomplish or needs to occur in order to no longer need this service or less of a service. Discharge plan tells how the member will know when they would be ready to discharge from that service. Must have a discharge plan for every service identified in service in Section 5: My Waiver/Habilitation Services (Medicaid Services) grid of PCSP.

Section 6: My Self-Management Plan - ICM

Standard	Type of Change	Clarification
Person-centered service plan addresses the member's **assessed health risks and safety risks.** ***combined standards 88/89 from previous workbook**	Standard Update	Location: Section 3: My Risk Factors & Needs * Section 6: My Self-Management Plan - Crisis and Safety Plan - My Medical & Behavioral Health Plan If there are health risks identified in assessment and other records those must be addressed in the person-centered care plan in one of the above three locations. Health & safety risks(s) must have a plan on how to minimize the risk and/or how to self-manage the health risk if identified select 2 (meets). If health & safety risks are notified in record, but not addressed in care plan select 1 (does not meet).
Person-centered service plan Includes **emergency backup support and crisis response system** to address problems or issues arising when support services are interrupted or delayed or when the member's needs change. * **Combined standards 90/91 from previous workbook**	Standard Update	Location: Section 6: My Self-Management Plan - My Backup Plan for Services - I hate these supports available in the event I need to enact my crisis/safety plan Person-centered care plan (PCSP) indicates that backup support plan is included in providers plan, but providers plan is not included in members record or at review select 1 (does not meet). Backup Plan for services grid must identify the name of the person, identify the backup plan/Backup Staff and Backup phone number and the table under to enact my crisis or safety plan must identify supports member has or will utilize including Provider Name and phone number if all are addressed select 2 (meets).

Self-Management: Crisis Plan – Non ICM

Standard	Type of Change	Clarification
The member has a crisis plan for mental and physical health as applicable to his/her diagnosis(es).  	Clarification	Addressing both physical health chronic conditions & mental health. This is all conditions that the member Crisis plans identify things that trigger or a warning signs for the condition, coping skills to use to help lesson the symptoms/condition, ways to minimize triggers to avoid hospital/emergency room Medical symptoms, managing symptoms and how others can support should be filled out to meet crisis plan for physical health. - Medical symptoms should be listed for significant physical health conditions (diabetes, hypertension, seizures, etc.) - If record indicates that member's physical health is impacting their life, this chart must be completed. - For lower risk physical health conditions that may not have specific or ongoing symptoms (e.g., obesity). Medical symptoms chart says, "none at this time" and comprehensive assessment and social history does not indicate a physical health select 2 (meets). Mental Health symptoms - My behavioral plan must answer triggers, early intervention plan, indicators, help myself and coping skills/natural supports. If the plan does not clearly define self management plan, select 1 (does not meet). If not completed by nurse or licensed care coordinator select 1 (does not meet).

Self-Management Plan – Non ICM

Standard	Type of Change	Clarification
The member has a self-management plan for mental and physical health as applicable to his/her diagnosis(es).	Clarification	Addressing both physical health chronic conditions & mental health Self-management items are ways to minimize triggers to avoid emergency room/hospitalization, coping skills they will try before accessing supports/services, attending appointments, taking special medications, therapies, etc. Medical symptoms (chronic conditions) should be completed for significant physical health conditions (diabetes, hypertension, seizures, etc.) - If record indicates that member's physical health is impacting their life, this must be identified. For lower risk physical health conditions that may not have specific or ongoing symptoms (e.g., obesity). The plan can identify "none at this time" and comprehensive assessment and social history does not indicate a physical health select 2 (meets). Mental Health symptoms - My behavioral plan must answer triggers, early intervention plan, indicators, help myself and coping skills/natural supports. If the plan does not clearly define self management plan, select 1 (does not meet). If not completed by nurse or licensed care coordinator select 1 (does not meet).

Activity – Self-Management Plan

- Jane is diagnosed with Major Depression with Manic Episodes, Arthritis, headaches, Asthma, back pain, COPD, Hepatitis C, Restless leg syndrome, sleep disorder, urinary incontinence, iron deficiency anemia and GERD.
- **My Risk Section**

Risk	Identified risk factors, needs, background	Measures in place to minimize, including back-up plans & strategies when needed
Physical Health	Barb reports she suffers from arthritis, back pain, headaches, asthma, COPD, Hepatitis C. Barb Hep C is by her physician. Also has RLS, sleep disorder, urinary in continence, iron deficiency anemia and GERD.	Barb will partner with staff to schedule and attend appointments, follow doctor's orders/recommendations and take medications as prescribed.

- **Medical Symptom Plan**

Medical Symptom	What I do to manage on my own	How others can support me
Back Pain	Take pain relievers	Others can support me by understanding my pain, and how it may affect my mood.
Headaches	Take pain relievers	Others can support me by understanding my pain, and how it may affect my mood.
Hiatal Hernia	Follow a health diet	Others can support me by understanding my pain, and how it may affect my mood.

Survey Q&A

- Question: Further clarification would be helpful regarding: "The member has a crisis plan for mental and physical health as applicable to their diagnoses". Does this refer to Section 5 of the PCCP and Section 6 of the PSCP, or does this require a separate crisis plan?
  - Answer: As long as the crisis section of the respective care plans are filled out completely and related to each member's individual diagnoses, symptoms, triggers, supports, etc., credit could be given for this standard and reviewers would not require a separate crisis plan outside of the care plan unless member requested any additional documents or formats for their own benefit.
- Question: Further clarification would be helpful regarding: "The member has a self-management plan for mental and physical health as applicable to his/her diagnoses".
  - Answer: Section 5 of PCCP and Section 6 of PCSP include a table where it can be identified how members manage their symptoms and diagnoses and how others can support them doing so. This aligns closely with crises plans and generally tie together on how symptoms, triggers and diagnoses can be managed as they arise for each member.

Section 7: My Right Restrictions - ICM

Standard	Type of Change	Clarification
Person-centered service plan documents the positive interventions and supports used prior, including less intrusive methods tried, to any modifications for the right restriction. **Combined standards 111/112 from previous workbook.**	Standard Update Clarification Update	Location: Section 7: My Right Restrictions - Past Interventions Tried I member does not have any applicable right restrictions i.e. minor child living with family select 0 (not applicable). Each right restriction must identify what previous interventions/supports were provided if states in place due to court order, social security requirement for payee select 2 (meets).
Person-centered service plan Includes informed consent of the member/legal representative and will cause no harm due to right restriction in place. **Combined standards 116/117 from previous workbook.**	Standard Update Clarification Update	Location: Section 7: My Right Restrictions - statement at beginning of template - I/my guardian agree to these right restrictions. These right restrictions will not cause undue harm. If member does not have any applicable right restrictions i.e. minor child living with family, select 0 (not applicable). If the 2 statements are on the person-centered service plan, select 2 (meets).

Survey Q&A

- Question: Can we have additional information or trainings regarding IHH's role regarding client rights restrictions?
  - Answer: Measures have been updated to reflect more detail of what is expected around rights restrictions documentation and monitoring.
    - MCOs and HHS will add this suggestion back to the Learning Collaborative workgroup to discuss a formal training! Any specific questions can be discussed with MCOs as needed.

Section 8: My Education & Employment - ICM

Standard	Type of Change	Clarification
If receiving prevocational services (T2015) and earning subminimum wages, the person-centered service plan includes the following: counseling, information, and referral regarding integrated community employment has been provided. **Combined standards 97 & 98 from previous workbook**	Standard Updated	Location: Section 8: My Education & Employment * I earn a subminimum wage * I was provided with counseling, information, and referral regarding community employment ___ by ___ with the following provided to me____. * I was not provided with counseling, information, and referral regarding community employment because. If Children's Mental Health Waiver only or not receiving prevocational services, select 0 (not applicable). If receiving prevocational services must answer all statements, if member is not receiving subminimum wage do not need to answer I was provided with counseling... select 2 (meets). I was not provided with counseling... has to be answered if receiving subminimum wage if the I was provided with counseling statement is not answered.
If receiving small group employment (H2023), the person-centered services plan includes, the number of members working in the group and the number of hours of work per week. **Combined standards 97 & 98 from previous workbook**	Standard Update	Location: Section 8: My Education & Employment * I am receiving small group employment * I work with __ (number) people in my group and ___hours a week. If Children's Mental Health Waiver only or not receiving small group employment services, select 0 (not applicable). If receiving small group employment must answer both statements, select 2 (meets).

Section 8: My Education & Employment

Standard	Type of Change	Clarification
If receiving individual supported employment (T2018), the person-centered services plan identifies the number of hours of employment per week and number of hours on-site staff support needed by the member per week. **Combined standards 102, 103, 104**	Standard Update	Location: Section 8: My Education & Employment * I am receiving supported employment * I work ___hours a week and have staff on site for support __hours a week.. If Children's Mental Health Waiver only or not receiving supported employment select 0 (not applicable). If receiving small group employment must answer both statements, select 2 (meets). if receiving long term job coaching answer both states select 2 (meets).

Section 9: Where I Live

Standard	Type of Change	Clarification
Person-Centered Service Plan identifies setting options from which the individual chose and meets the home and community- based setting requirement. **Combined standards 71, 72**	Standard Update	Location: Section 9: Where I Live - I choose the setting in which I live now - I selected the setting where I live amount available alternatives All statements above must be answered, if no is an answer an explanation must be identified to select 2 (meets).
If member is receiving home-based habilitation (H2016), the person-centered service plan identifies the number of other Home and Community Base Services habilitation/waiver consumers who live with the member in the living unit. **Combined standards 105/108**	Standard Update	Location: Section 9: Where I live - I have __members with home-based hab or supported community living services also living in my home with me. If not receiving home-based habilitation or Children's Mental Health Wavier ONLY select 0 (not applicable). If receiving H2016 statement must be answered even if living in own apartment select 2 (meets).
If member is receiving home-based habilitation (H2016), the person-centered service plan identifies the number of hours per day of on-site staff supervision needed. **Combined standards 105/107**	Standard Update	Location: Section 9: Where I live * I am receiving home-based habilitation services - I need __ hours of supervision a day If not receiving home- based habilitation or Children's Mental Health Waiver ONLY select 0 (not applicable). If receiving H2016 above statements must be answered even if living in own apartment select 2 (meets).
If member receiving home-based habilitation (H2016), the person-centered service plan identifies member's living environment. **Combined standards 105/106**	Standard Update	Location: Section 9: Where I live * I am receiving home-based habilitation services - The living environment is If not receiving home-based habilitation or Children's Mental Health Waiver ONLY select 0 (not applicable). If receiving H2016 above statement needs to identify living environment, if identified select 2 (meets). If does not identify select 1 (does not meet).

FORMS

HCBS Residential Assessment - ICM

Standard	Type of Change	Clarification
The Home and Community Base Services Residential Setting Member Assessment (Form 470-5466) was completed in IMPA within the review period.	Standard Update Clarification Update	If assessment is completed in IMPA during the review period, select 2 (meets). If assessment is not completed in IMPA (electronically) during the review period, select 1 (does not meet). All Habilitation and Children's Mental Health Waiver members are required to have this completed at least annually. Prior to 1/1/2024, document would be uploaded into IMPA under documents and a copy in the record.
If disenrolled, health home followed disenrollment requirements.	Clarification Update	Requirement per Health Home Manual include: * Date of disenrollment * Reason for disenrollment * How the member's needs will be supported after disenrollment * That the health home has advised the member of ability to re-enroll if circumstances change. If all are identified select 2 (meets). If an item is missed select 1 (does not meet). If member is still enrolled select 0 (no applicable). Health home notification form for disenrollment would count if all items are addressed above. A narrative contact note stating disenrollment information is also required.

Other measures moved to this section:

Health Risk Screener/Assessments (HRS/HRA), Risk Stratification, Notice of Decisions (NOD) & Person-Centered Service Plan Incident Form

Survey Q&A

- Question: ICM Forms Section states Form 470-5466 (Residential Setting Assessment) has been completed and uploaded into IMPA. Should this be revised since the form is now completed IN IMPA?
  - Answer: Yes! Wording has been changed to reflect "completed" in IMPA rather than uploaded.
- Question: There is a measure about the Health Risk Screener being completed during the review period, but members may choose not to complete this despite IHH encouragement. How do we ensure we can obtain credit for this, as not all MCOs provide an option to complete this on behalf of the member?
  - Answer: The Health Risk Screener can identify risks and areas of need, and member answers can inform the assessment and care plans and subsequent supports. While it would be a helpful tool for member and their care team to utilize, there is still a possibility for an IHH to obtain credit on this standard even if member declined to complete the Health Risk Screener. If there is documentation that IHH encouraged member to complete this, and/or offered to support them with completing the Health Risk Screener, credit may still be given. Please note the Health Risk Screener is not a requirement for FFS members without MCO involvement.

Risk Stratification – Non ICM

Standard	Type of Change	Clarification
There is a risk stratification noted in the chart completed during review period.	Clarification	If actual risk start tool is included in record or if records indicate that risk strat was completed and score/risk level was noted select 2 (meets). If risk strat tool is included in record but is not dated and there is no contact note indicating that it was completed select 1 (does not meet). If risk strat identifies Children's Mental Health Waiver or Habilitation as a risk select 1 (does not meet). Children's Meant Health Waiver and Habilitation are services that are used to support the members identified needs and risk and the services are used to decrease the risk and/or need.

Core Service Standards

Care Coordination - Contact Notes (Non ICM)

Standard	Type of Change	Clarification
Record shows documentation of outreach attempts to engage the member in care coordination.	Clarification	Need to see attempts to reach member e.g. phone calls, text messages, letters, however this is not a billable service. Attempts to engage select 2 (meets). Sending newsletters/mailings only select 1 (does not meet). If only one attempt is made during the month select 1 (does not meet). This must align with the health home policy. If not clear will need to request from Health Home.
Record demonstrated monitoring and intervening on progress of member treatment goals.	Clarification	Documentation of conversation with member specifically around progress of goals select 2 (meets). If care gaps are identified in the goals and there is documentation of reviewing for gaps in care where they looked for gaps and what was identified and includes the follow-up to those gaps select 2 (meets). All care plan goals must be documented on during the review period select 2 (meets). If goals are built into the note template, the note should specifically document updates to the goals and/or details of the discussion around the goals select 2 (meets). When reviewing progress of goals looking each goal identified where is the member at in the progression towards meeting the goal, any barriers identified for not meeting the goal, if goal was met were any new goals identified.

Care Coordination - Contact Notes (Non ICM)

Standard	Type of Change	Clarification
There is documentation of coordination with multiple systems for children when appropriate.	Clarification	Examples of systems: school (IEP/504 plan meetings), Health Human Service (HHS) workers, foster parent, adoption specialist, Juvenile Court Officer (JCO), PMIC, BHIS, etc. If there are no concerns or is not a minor, select 0 (not applicable). If member/parent expresses concern w/school, HHS, JCO, PMIC, or any children services. If coordination is documented with those entities, select 2 (meets). If not select 1 (does not meet). Must see referral and/or discussion of other services available prior to referrals to higher level of care/systems..

Reminder our purpose is to provide whole-person and person-centered care and our documentation should be reflective of that.

Health Promotion – ICM & Non-ICM

Standard	Type of Change	Clarification
There is documentation of ongoing health promotion activities specific to the member's needs.  	Clarification Update	Health Promotion is engaging members in their own health around the areas of prevention, managing chronic conditions (Physical, Mental, Behavioral), and SDOH though a person-centered approach. Includes things like preventative care- Flu shot reminders, immunizations, childhood screenings, annual PCP visit reminders, dental, other routine screenings (mammogram, pap smear, etc.), medication adherence/education. May be identified through gaps review, but the gap in care must be identified and the follow-up regarding the gap in care. Look for red flags- if member has conditions that are not addressed select 1 (does not meet). Education regarding diagnosis and addressing self management plans. Must be specific to members needs to select 2 (meets). The assessment should identify all gaps to expect throughout the year based on age, sex, conditions, and risk. The plan should outline how they are all monitored. The services should address the gaps. If this occurs, we shouldn't be reviewing files for gaps in care. promotes health management, improved disease outcomes, disease prevention, safety, and an overall healthy lifestyle **"Health promotion is the process of enabling people to increase control over, and to improve their health." Health Promotion Glossary, 1998**

Transition of Care – ICM & Non-ICM

Standard	Type of Change	Clarification
Crisis plan was reviewed and updated with any changes needed.	Clarification Update	If member was not hospitalized or discharged from hospital level facility (PMIC, group care, nursing facility, physical/mental health hospitalizations) select 0 (not applicable). Need to see if contact note or person-centered service plan (PCSP) incident form is completed indicated that crisis plan was reviewed and/or updated for. If identified select 2 (meets).
There is documentation of communication with the member regarding 7-day follow-up.	Clarification Update	If member was not hospitalized or discharged from hospital level facility (PMIC, group care, nursing facility, physical/mental health hospitalizations), select 0 (not applicable). Looking for note on conversation with member regarding follow-up appointment addressing any barriers/concerns preventing them from attending. This is for both physical health and mental health hospitalizations. This is a specific health home core measure (mental Health) and HEIDIS measure for both.
There is documentation that medication reconciliation is completed during post-discharge follow-up visit.	Clarification Update	If member was not hospitalized or discharged from hospital level facility (PMIC, group care, nursing facility, physical/mental health hospitalizations) select 0 (not applicable). Obtaining hospital discharge med list, ensuring member filled new prescriptions, & does member understand med changes including discontinuation of meds prior to hospitalization. The Nurse must complete this measure, if completed by another role this would be 1 (Does not meet).

IOWA HHS

Activity

Blobs and Lines

- **Have you ever talked with a member or guardian who was disgruntled and felt like you were able to improve how they felt by the end of the conversation?**
- **Do you feel like you understand the components of the core services outlined in the IHH program.**
- **Do you prefer to work with ICM or Non ICM members?**
- **Do you prefer Data work or Member interaction?**

New Standards - ICM

Inter-RAI (Children's Mental Health Waiver Only) - ICM

Standard	Type of Change	Clarification
InterRAI is present in the member's record.	Standard Update Clarification Update	For Children's Mental Health (CMH) waiver members only, if not CMH select 0 (not applicable). For Fee For Service (FSS), Molina and Iowa Total Care (after 3/1/24), if current copy is in the health home file select 2 (meets). If no copy in the health home file select 1 (does not meet). For Wellpoint, InterRAI must be completed within 365 day of the previous assessment, unless a valid exception is documented. See standard 21 for approved exceptions. If after 365 days and no valid exception identified select 1 (does not meet).

Standard	Type of Change	Clarification
InterRAI is signed by the member and legal representative.	Standard Update Clarification Update	If health home did not complete the InterRAI select 0 (not applicable). If health home completed InterRAI did the member/legal representative sign or did the health home document why the guardian did not sign select 2 (meets). If not signed by member/legal repetitive select 1 (does not meet).

Comprehensive Assessment & Social History General Requirements - ICM

Standard	Type of Change	Clarification
Comprehensive Assessment & Social History is signed by the member/legal representative.	Standard Update Clarification Update	Signature or electronic signature has to be on the comprehensive assessment and social history (CASH) to be a valid CASH, if not signed select 1 (does not meet). The person who complete the assessment with the member must sign the CASH, either Nurse or Care Coordinator. If other roles provide input they don't need to sign assessment but should see a note in record that they offered input. If nurse does not complete with the member, we must see a note in the record that nurse reviewed it in the record. This does not prevent the CC from submitting it to the Managed Care Organization An intern can complete the CASH, as long as the RN or CC provide supervision during the meeting. As of 2/15/2024, all CASH must be completed in person with the member, if not select 1 (does not meet). Prior to 2/15/24, member/legal representative signature line may be typed in if the assessment was not done in person with a statement on why it was not completed in person. For adults with a guardian, if guardian is not present for the meeting, documentation must be present on why. If documented select 2 (meets).

Removed Standards or Combined with other Standards for ICM

ICM Standards Removed

Standard		Standard
If the member has transitioned to this health home from a previous health home, the person -centered service plan was updated within 30 days.		The Comprehensive Assessment and Social History is completed entirely. (All questions are answered, including explanations and comments)
Health Home followed up to ensure that the member had been reassessed for clinical depression. **Combined with another measure**		BMI recorded for members ages 18-74. **Non ICM and ICM**
The person-centered service plan reflects the clinical and support needs as identified.		Three are incremental action step identified
The person-centered service plan identifies barriers to meeting goals or implementing the plan.		PCSP indicates that the member lives in a setting that meets the home and community-based setting requirements.
PCSP documents that the member selected the setting among setting options.		Day Habilitation (T2020/T2021) Services are coordinated with any physical, occupational, or speech therapies in the service plan.
a) Document less intrusive methods of meeting the need that have been tried but did not work.		The person-centered service plan was revised on or before the member's annual due date.
HCBS Residential Setting Member Assessment (Form 470-5466) is included in the member's record.		There is documentation that alternative HCBS setting were considered by the member.

Survey Q&A

- Question: Will we be able to see which measures were removed from the new workbook?
  - Answer: Yes! There will still be a Change Tracker tab like in previous versions.

Questions