HEALTH WEALTH CAREER

PCMH+ WAVE 2 COMPLIANCE REVIEW

FIRST CHOICE HEALTH CENTERS, INC.

MAY, 2019

State of Connecticut

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1 INTRODUCTION

The Person Centered Medical Home Plus (PCMH+) program was launched on January 1, 2017 as part of the Connecticut Department of Social Services (DSS) investment in value-based purchasing care coordination. PCMH+ provides person-centered, comprehensive coordinated care to HUSKY members. PCMH+ builds on the success of Connecticut Medicaid's Person-Centered Medical Home (PCMH) program which works to improve quality of care and the overall health of HUSKY members. PCMH+ Wave 2 launched on April 1, 2018 after the successful completion of Wave 1. PCMH+ Wave 2 will build on both the existing PCMH program and PCMH+ Wave 1 by focusing on Enhanced Care Coordination Activities and Care Coordination Add-On Activities related to the integration of primary care and behavioral health care, provider competencies to support Medicaid members with complex medical conditions and disability needs, and promoting linkages to community supports that can assist members in utilizing their Medicaid benefits. DSS retained Mercer Government Human Services Consulting (Mercer) to evaluate the PCMH+ program and conduct reviews of PCMH+ Participating Entities (PEs).

PCMH+ is a shared savings model where PEs that meet identified benchmarks on quality performance standards and under-service prevention requirements, while reducing Medicaid expenditures and improve HUSKY member health outcomes may share in a portion of program savings. Quality measure scoring and PCMH+ program savings calculations for Wave 2 will be conducted in Fall 2019 and, therefore, are not evaluated as part of this PCMH+ compliance review. This review focuses solely on evaluating PCMH+ PE compliance with PCMH+ Wave 2 program requirements, identifying best practices and opportunities for improvement.

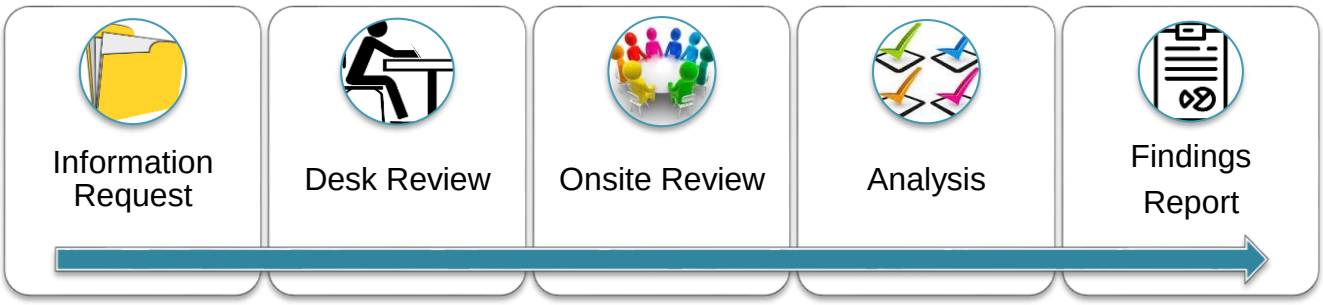
PCMH+ PROGRAM REQUIREMENTS

The PCMH+ program provides care coordination services to all PCMH+ assigned members through a set of required Enhanced Care Coordination interventions. For PEs that are Federally Qualified Health Centers (FQHC), there are additional “Add-On Care Coordination” requirements that further drive behavioral health (BH) integration within the practice. The following table provides a high-level summary of the PCMH+ program requirements and the areas of evaluation for this review. Additional details regarding specific requirements are located in Section 3.

PROGRAM OPERATIONS	ENHANCED CARE COORDINATION	COMMUNITY LINKAGES
• Current participant in DSS' PCMH program • Operate an oversight body with substantial participation by PCMH+ members • Identify a PCMH+ senior leader and clinical director • Employ sufficient and qualified staff to provide enhanced care coordination services • Submit monthly reporting to DSS • Develop a planned approach to monitor, identify and address under-service	• Physical Health (PH)–BH Integration • Children and Youth with Special Health Care Needs (CYSHCN) • Competencies in Care for Individuals with Disabilities • Cultural Competency	• Implement or enhance contractual relationships or informal partnerships with community partners to impact social determinants of health (SDoH) • Sponsor local community collaborative forums or participate in existing forums • Demonstrate results of engaging in partnerships with community partners

REVIEW METHODOLOGY

The PCMH+ Wave 2 compliance review assessed for compliance, quality, and effectiveness in achieving the goals of the PCMH+ program for the period of June 2018 to February 2019 and was organized into five phases presented in the diagram below:



Information Request — January 2019

Mercer submitted an information request to each PE in January 2019. The information request solicited a variety of documents and materials in an effort to gain an understanding of PE's program compliance, operations, and approach in implementation of PCMH+. The information request included but was not limited to member files, organizational charts, PCMH+ staffing, policies and procedures, narrative responses, underservice policy, and other relevant information related to the implementation of the PCMH+ program. PEs were also asked to compete a program questionnaire.

Desk Review — February 2019

Mercer received information electronically from the PEs and conducted a desk review of all submitted material. Areas where Mercer could not determine if a process or procedure was compliant with PCMH+ program standards were noted for follow-up discussion during onsite review.

Onsite Review — March 14, 2019

The onsite review for First Choice Health Centers, Inc. (FCHC) took place on March 14, 2019, at their 809 Main Street, East Hartford, Connecticut office. The onsite review began with an introductory session with the DSS staff, the Mercer team and FCHC leadership and PCMH+ dedicated staff. As part of the introduction, FCHC presented a PCMH+ program implementation overview. Mercer and DSS conducted interviews with FCHC staff that focusing on: PCMH+ Program Operations, Enhanced Care Coordination, Community Linkages, and Member Interviews. FCHC staff interviews included:

- Eugene Market, CEO
- Jeffery Steele, CFO
- Samantha Taylor, COO
- Vasanth Kainkaryam, CMO
- Colleen Rankine, Patient Engagement Manager
- Samantha Moberger, Director of Quality Assurance & Performance Improvement
- Sheila Sutton, Director of Care Management
- Kristen Goiangos, Interim Director of Behavioral Health
- Iris Acosta, Behavioral Health Care Coordinator
- Ivette Santiago, Care Coordinator
- Norma Palacios, Care Coordinator
- Rubina Bhura, AmeriCorps

Analysis and Findings Report — May 2019

During all phases of the Wave 2 onsite compliance review, information was gathered and a comprehensive review was completed. Results of the comprehensive review is the basis for this report.

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SUMMARY OF FINDINGS

FIRST CHOICE HEALTH CENTERS, INC. PCMH+ PROGRAM OVERVIEW

FCHC is a FQHC with 12 locations located throughout East Hartford, Manchester and Vernon, Connecticut. FCHC provides a full continuum of primary care and specialist care to its members including: BH, dental, infectious disease, geriatrics, pediatric, podiatry, optometry and women's health. Additional services offered by FCHC include a mobile dental clinic, five school-based health centers, Parents as Teachers program, SNAP and a free fitness center onsite for members.

FCHC provides care coordination for 7,750 PCMH+ members. FCHC employs three full-time employee (FTE) care coordinators and one FTE BH care coordinator. All care coordinators are bilingual, utilize a team-based approach, and are 100% dedicated to the PCMH+ program. The four care coordinators are assigned to FCHC's four larger sites. For the sites that do not have an assigned care coordinator, a referral is sent through the electronic medical record (EMR), and care coordinators can then travel to the other location to meet with members and provide care coordination services. Care coordinators are supervised by the Patient Engagement Manager. Oversight of the PCMH+ program is the responsibility of two Clinical Directors who report to the Performance Improvement Committee. The Committee then reports directly to the Board of Directors.

FCHC reports an average penetration rate of less than 1%. The penetration rate is based on the number of unique member contacts per month divided by the assigned PCMH+ membership. Since the start of Wave 2, FCHC has reported the following unique member contacts per month: June 2018: 123 members; July 2018: 61 members; August 2018: 80 members; September 2018: 64 members; October 2018: 87 members; November 2018: 45 members; December 2018: 19 members and January 2019: 55 members. FCHC's care coordinators average 23.25 care coordination contacts per month. It is important to note that a ramp-up period is typical for newly implemented programs.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	FCHC has established a strong clinical team who provides leadership and oversight of the PCMH+ program. It is clear that the FCHC leadership team is committed to the vision and mission of PCMH+.

REVIEW AREA	STRENGTH
	FCHC has established an oversight body and recruited members to participate on the body. This oversight body meets at least quarterly and includes substantial representation by PCMH+ members.
	FCHC is developing a telehealth care service line for BH and medical care as well as developing a home health team program where a licensed clinical social worker (LCSW), registered nurse (RN) and advanced practice registered nurse (APRN) travel together to assess the member in the home environment.
	FCHC has revised their risk stratification model to include level of member engagement in their health care. A member's readiness to change is assessed through motivational interviewing techniques and, in turn, the team uses different approaches to improve member engagement.
Under-Service	FCHC has an established under-service methodology which monitors, identifies and addresses underservice. The methodology incorporates the utilization of E-Consults, quarterly peer review and self-peer review, interdisciplinary meetings and standing orders.
Physical Health-Behavioral Health Integration	FCHC utilizes a variety of valid and reliable smart forms to screen its member population for potential BH risks across its medical, dental and other specialty practices. These tools include: The Audit C (measures potential alcohol abuse), the Drug Abuse Screening Tool (DAST), the Patient Health Questionnaire (PHQ) 2 & 9 (measures for depression), the GAD 7 (measures for Generalized Anxiety Disorder), Tobacco Control assessment, Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), CRAFFT (identifies substance use, substance-related riding/driving risk in youth), PEDS (developmental-behavioral screening for children), Modified Checklist for Autism in Toddler (MCHAT) and Pediatric System Checklist (PSC).
	FCHC utilizes a unified record that incorporates BH and PH. This record enables the ability to create a care plan in partnership with both departments. FCHC has transitioned from co-location of BH to an integrated transdisciplinary model of BH in primary care. BH and PH providers function in solidarity as a team and share responsibility for clinical quality metrics.
	FCHC has incorporated the American Academy of Pediatrics' recommendations on the age of transition and developed a five question model for Transition Age Youth which is embedded into the EMR. There was evidence in the member file of scored elements, which ranged from being able to explain the reason for a physician visit, how to make an appointment, and privacy and confidence in taking care of health needs without help.
Children and Youth with Special Healthcare Needs	FCHC partners with the University of St. Joseph Behavior Analysts to present on services available to the CYSHCN population. Presentations focus on how to target the population and what skill sets are needed to provide services to these individuals.

REVIEW AREA	STRENGTH
Cultural Competency	FCHC staff receive cultural competency training during the onboarding process as well as annually thereafter. Training is provided through an online training program HealthStream When FCHC leadership identifies a training need for a specific population, in-house specialized trainings are established to address the need.
	Three FCHC care coordinators are bilingual, and some are certified interpreters. FCHC's member portal is available in both English and Spanish. FCHC is planning to explore the community resource platform "Aunt Bertha" to print member resources in different languages. FCHC has recently changed their patient education vendor to HealthWise to utilize a more appropriate level of language. All FCHC websites are Americans with Disabilities Act (ADA) compliant.
	FCHC has hired a dietician who is quadrilingual to better meet member's cultural needs, particularly around diet.
	FCHC's leadership team is diverse and representative of the patient population. FCHC staff name tags feature the staff member's preferred pronoun. They require all medical assistants to be bilingual to ensure that they have medical translators on staff.
	FCHC is in process of opening a LGBTQ center to provide services to individuals of all ages.
Community Linkages	FCHC uses the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) screening tool to assess all adult members for SDoH and the Survey of Well-being of Young Children (SWYC) screening tool for children. PRAPARE is a nationally-recognized evidenced-based practice tool which assesses for race, education, employment, ethnicity, income, language, housing status and stability, transportation, social integration and support, stress, etc. The SWYC tool assesses development, behavior, Autism Spectrum Disorder risk, family context in children ages one through 65 months. The results of these assessments are then recorded in the member's file.
	FCHC has a free fitness center onsite that all members may use.

OPPORTUNITIES FOR IMPROVEMENT

The table below represents the opportunities for improvement identified during the desk and onsite review process. A detailed "Recommendations for Improvement Plan" can be found in Appendix A of this report.

Please note that identification of CYSHCN and members with disabilities posed challenges for the many of the PEs and therefore, the challenges identified at this PE are not unique. DSS recognizes that definitions for these populations vary and identification of these members is new for PEs under the PCMH+ program. As such, DSS will continue to provide technical assistance to assist the PEs to meet the requirements of PCMH+ for these specialty populations.

REVIEW AREA	OPPORTUNITY
Program Operations	FCHC's penetration rate has remained below 1% since the start of Wave 2.
Physical Health-Behavioral Health Integration	FCHC is developing processes to document if a member has a psychiatric advance directive and methods to extract this data point for the monthly reports.
	FCHC is developing processes to document if a member has a Wellness Recovery Action Plan and methods to extract this data point on the monthly reports. FCHC is currently using a plan of care as their Wellness Recovery Action Plan but it is not recovery-oriented. FCHC recognizes this as an area of growth.
	While FCHC has a policy in place regarding transitioning a youth to an adult provider, has incorporated the American Academy of Pediatrics' recommendations on the age of transition, and developed a five question model for Transition Age Youth. Member files for Transition Age Youth did not contain care coordination notes. Two of the records contained a section assessing for "Transition to Readiness to Adult Model of Care" but there was no follow up or next steps.
Children and Youth with Special Healthcare Needs	FCHC is developing processes regarding advance care planning with CYSHCN and recognize this as an area of growth.
	Member files for CYSHCN showed a lack of care coordination notes or limited follow up for CYSHCN members.
	FCHC is developing processes regarding the collection of school-related information (e.g., individualized education plans or 504 Plans) but reviewers did not find evidence of school-related information in the member files.
Competencies Caring for Individuals with Disabilities Requirements	FCHC is developing processes to identify and consistently flag members with disabilities in the EMR.
	FCHC is developing processes to extract data from their EMR in order to report on counts of members with disabilities and counts of members who have received an adjusted appointment time.
	FCHC disability files identified some member needs but the notes were brief and follow up was inconsistent.
	FCHC is developing a staff training plan to the unique needs of members with disabilities.
Cultural Competency	FCHC's member files did not show evidence of cultural needs being incorporated into the member's plan of care.

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DETAILED FINDINGS

PCMH+ PROGRAM OPERATIONS

PCMH+ Program Operations Requirements

PCMH+ PEs are required to be current participants in the DSS PCMH program and hold Level 2 or Level 3 PCMH recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from the Joint Commission. Additional program requirements include:

- Operate an oversight body with substantial participation by PCMH+ members
- Identify a PCMH+ senior leader and clinical director
- Employ sufficient and qualified staff to provide enhanced care coordination services
- Submit monthly reporting to DSS

PCMH+ Program Operations Findings

- FCHC has established an oversight body and recruited members to participate on the body. This oversight body meets at least quarterly. FCHC reports holding one PCMH+ Oversight Committee in September 2018 for 15 members, seven of which were PCMH+ voting members and one PCMH+ Oversight Committee in December for 16 members, six of which were PCMH+ voting members.
- FCHC is developing a telehealth care service line for BH and medical care as well as developing a home health team program where a LCSW, RN and APRN travel together to assess the member in the member's home.
- FCHC has revised their risk stratification model to include level of member engagement in their health care. A member's readiness to change is assessed through motivational interviewing techniques and, in turn, the team uses different approaches to improve member engagement.
- FCHC has identified two clinical directors (Vasanth Kainkaryan and Sheila Sutton) who provide oversight and leadership for the PCMH+ program. Vasanth Kainkaryan is dedicated to the program 10% of the time while Sheila Sutton is dedicated to the program 25% of the time.

- FCHC employs three FTE care coordinators and one FTE BH care coordinator and utilizes a team-based approach. The core primary care team consists of a provider, medical assistant and a nurse. Other members on the team include a care coordinator, who may perform medical care coordination or social service care coordination, a BH care coordinator, dental providers, podiatry providers, etc. Not all sites have a full-time care coordinator. For these sites, member's care coordination needs are served by a referral through the EMR. Care coordinators then travel to the other locations to provide the care coordination required. In the case of care coordination vacancies, the current primary team members will ensure those needs are met. If needs such as social service resource knowledge are outside of the skill-set of the primary team members, a referral is completed and sent to a care coordinator within FCHC, who will work with the team to resolve the referral. The Patient Engagement Manager will also assist to resolve any social service care coordination needs. FCHC's staffing model appears to be sufficient for the volume of PCMH+ members assigned.

- FCHC utilizes members of AmeriCorps. These members focus on specific projects identified by FCHC leadership as a priority for their organization. Presently, one member of AmeriCorps has been focusing on population health. In the past, members have focused on emergency department utilization. These members have also been engaged in identifying community resources for PCMH+ members. AmeriCorps members are supervised by the leadership member running their specific project.

- FCHC is assigned 7,750 PCMH+ members and reports an average penetration rate of less than 1%. The penetration rate is based on the number of unique member contacts per month divided by the assigned PCMH+ membership. FCHC's care coordinators average 23.25 care coordination contacts per month.

- At times, FCHC's care coordinator notes were brief and did not consistently reflect follow up. There were some documented efforts of assistance (e.g., helping a member get an electric wheelchair) but these were listed within a nursing note and not labeled as care coordination notes.

- FCHC submits the PCMH+ monthly report on timely basis each month.

UNDER-SERVICE

Under-service Requirements

In order to ensure that savings within the PCMH+ program do not result from limitations on members' access to medically necessary services, or members with complex care needs are not removed from a PE's practice for reasons associated with high-cost. Requirements include:

- Develop a planned approach to monitor, identify and address under-service. The approach must be designed to monitor and identify potential underservice utilization or inappropriate reductions

in access to medically necessary care that includes prohibiting these practices and educating staff.

- PEs will be disqualified from receiving shared savings if they demonstrate any or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality.

Under-service Findings

- FCHC has an established under-service methodology which monitors, identifies and addresses underservice. The methodology incorporates the utilization of E-Consults which allow the specialist's opinion to impact clinical decisions and appropriateness of referrals, quarterly peer review and self-peer review (to assess use of clinical guidelines and appropriateness of care), interdisciplinary meetings (to review high-risk members and improvement of engagement with these members) and standing orders which incorporate standard clinical guidelines. Any identified trends are reported to the Performance Improvement Committee and used as guidance for any "Meetucation" topics. FCHC also provides training to staff on alternative payment models and shared savings to further examine ways that under-service may take place.

- The desk and onsite review conducted by Mercer did not detect under-service.

ENHANCED CARE COORDINATION

PH-BH Integration Requirements

Requirements for PH-BH integration align with the goals of the PCMH+ program. PCMH+ PH-BH requirements include:

- Use of standardized tools to expand BH screenings beyond depression.

- Promote universal BH screening across all populations, not just those traditionally identified as high risk.

- Obtain and maintain a copy of psychiatric advance directives in the member file.

- Obtain and maintain a copy of a member's Wellness Recovery Action Plan in the member file.

- FQHCs only: Employ a care coordinator with BH experience who serves as a member of the interdisciplinary team and has the responsibility for tracking members, reporting adverse symptoms to the team, providing patient education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen, delivering psychosocial interventions, and making referrals to behavioral health services outside of the FQHC as needed.

- FQHCs only: Expand development and implementation of the care plan for Transition Age Youth with BH challenges.

- FQHCs only: Develop Wellness Recovery Action Plans or other BH recovery planning tools in collaboration with the member and family.

- FQHCs only: Use of an interdisciplinary team that includes BH specialists, including the required BH Care Coordinator.

PH-BH Integration Findings

- FCHC utilizes a variety of valid and reliable smart forms to screen its member population for potential BH risks across its medical, dental and other specialty practices. These tools include: The Audit C, DAST, PHQ 2 & 9, the GAD 7, Tobacco Control assessment, PRAPARE, CRAFFT, PEDS, MCHAT and PSC.

- FCHC utilizes LCSWs who are embedded into care teams based on expertise and clinical specialization. These LCSWs attend huddles, disciplinary meetings and engage in warm hand-offs for crisis interventions. FCHC has a system that makes accessing the LCSWs easy by providing quick access to BH appointments.

- FCHC's BH care coordinator attends weekly BH department meetings and helps to identify members who might be at risk of dropping out of these services. The BH care coordinator keeps members engaged and connects them to community resources as needed.

- FCHC uses a structured time slot method for their monthly interdisciplinary team meetings. Monthly reporting shows one interdisciplinary team meeting has been held per month since FCHC entered into the PCMH+ program. High-risk members from one provider's panel are selected and all team members are brought together to evaluate gaps in gap and engagement. BH care coordinators are included in these meetings.

- FCHC utilizes a unified record that incorporates BH and PH that allows for the development of a care plan by both departments. FCHC has transitioned from co-location of BH to an integrated transdisciplinary model of BH in primary care. BH and PH providers function in solidarity as a team ensuring that all providers are responsible for clinical quality metrics.

- FCHC is developing processes to obtain and maintain a copy of a member's psychiatric advance directive for the member file. Additionally, FCHC's EMR does not currently have the capacity to extract this data point in order to report counts of advance directives on the monthly report. FCHC has developed a workflow but has not reported on psychiatric advanced directives on their monthly reports entering the PCMH+ program.

- FCHC is developing methods to extract data from the EMR pertaining to Wellness Recovery Action Plans and has not reported on counts of Wellness Recovery Action Plans on their monthly reports. FCHC has identified a Wellness Recovery Action Plan in the members file but it

is more of a plan of care. This plan of care needs to be expanded to focus more on the member's recovery and quality of life to be considered a recovery tool.

- FCHC has a policy in place regarding transitioning a youth to an adult provider. FCHC has incorporated the American Academy of Pediatrics' recommendations on the age of transition and developed a five question model for Transition Age Youth, which is embedded into the EMR. On average, FCHC reports 208 PCMH+ Transition Age Youth members per month. There was evidence in the member file of scored elements, which ranged from being able to explain the reason for a physician visit, how to make an appointment and privacy and confidence in taking care of health needs without help. However, the same member files did not contain care coordination notes. Two of the records contained a section assessing for "Transition to Readiness to Adult Model of Care" but there was no follow up on next steps.

- FCHC stated that they are in the process of developing a substance use disorder intensive outpatient program.

Children and Youth with Special Health Care Needs Requirements

CYSHCN and their families often need services from multiple systems — health care, public health, education, mental health and social services. PCMH+ requirements include:

- Require advance care planning discussions for CYSHCN.

- Develop advance directives for CYSHCN.

- Including school-related information in the member's health assessment and health record, such as: The IEP or 504 Plan, special accommodations, assessment of member/family need for advocacy from the provider to ensure the child's health needs are met in the school environment.

Children and Youth with Special Health Care Needs Findings

- FCHC reports an average of 194 PCMH+ CYSHCN members per month and is developing processes regarding advance care planning with this population. FCHC recognizes this as an area of growth.

- FCHC had the University of St. Joseph Behavior Analysts present on services available to the CYSHCN population. The presentation focused on how to target the population and what skill sets are needed to provide services to these individuals.

- Most of the CYSHCN files did not contain care coordination notes or there was limited follow up. For instance, in one file, the reason for the appointment was listed as needing a letter for incontinence diapers. The APRN indicated she would write a letter and there is brief note that the letter was faxed. Other files included notes demonstrating attempts to schedule a member for appointments.

- FCHC is developing processes for working with schools to obtain member's IEPs and 504 Plans. FCHC has not reported on this area in their monthly reporting since entering the PCMH+ program. There was no evidence of any school-related information in the member file review with the exception of an assessment where the care coordinator asked the member if there were any problems or issues in school.

Competencies Caring for Individuals with Disabilities Requirements

PCMH+ requirements for individuals with disabilities pertain to include:

- Expand the health assessment to include questions about: Durable medical equipment (DME) and DME vendor preferences, home health medical supplies and home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds, and special physical and communication accommodations needed during medical visits.

- Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.

- Develop and require mandatory staff disability competency trainings to address the care of individuals with physical and intellectual disabilities.

- Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, a high/low exam tables) and communication adaptive equipment.

- Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment).

- Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g., mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a patient with cerebral palsy who experiences spasticity or tremors during a physical examination).

Competencies Caring for Individuals with Disabilities Findings

- FCHC reports that members with disabilities are identified using ICD-10 codes from their problem list. FCHC reports their EMR does not have the ability to identify members with disabilities and they have not reported on the number of members with disabilities on monthly reports since entering the PCMH+ program. FCHC has also not reported on the number of members who have received adjusted appointment times.

- FCHC disability files identified some member needs but the notes were often brief and follow up was inconsistent. There were no flags in the member file to indicate that the member had a disability. In one file, a member was requesting a letter for an electric wheelchair due to having a leg amputation. The letter was faxed but there was no follow up to determine if he received the chair. Another file identified the need for a nurse to help with activities of daily living and medication and a need for an evaluation for handicap equipment in the apartment, but the file did not contain any follow up notes.

- FCHC utilizes “global alerts” to identify members with disabilities but during the member file review these alerts were not always present. If the global alert was present and needs identified, it was not always clear if it was the nurse’s or care coordinator’s responsibility to ensure these needs were met.

- FCHC stated they are in the process of developing a staff training plan pertaining to the unique needs of members with disabilities.

- FCHC reports that they use language lines, TTY relay services and video relay services to address physical barriers to care. There was no evidence in the member files that the PE provides adaptive communication resources.

Cultural Competency Requirements

PCMH+ program Cultural Competency requirements include:

- Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities.

- Expand any individual care plan currently in use to include an assessment of the impact culture has on health outcomes.

- Compliance with culturally and linguistically appropriate services (CLAS) standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.

Cultural Competency Findings

- FCHC staff receive cultural competency training during the onboarding process as well as annually thereafter. The training is provided through HealthStream’s online platform and discusses cultural competency in patient-provider interactions looking at assumptions, guidelines and best practices, assessing accurately across cultures, cross-cultural care and patient compliance.

- All three FCHC care coordinators are bilingual. Some of the staff are certified as interpreters. FCHC’s member portal is available in both English and Spanish. FCHC stated that they are planning to explore Aunt Bertha to utilize the ability to print member resources in different

languages. FCHC has recently changed their patient education vendor to HealthWise to utilize a more appropriate level of language. All FCHC websites are ADA compliant.

- FCHC uses language lines which utilize qualified language interpreters who are also proficient in sign language. TTY Relay services and Video Relay Services can be accessed by the staff as well.

- FCHC stated that they are bringing a dietician on board who is Quadra lingual. They are using this as another way to meet their member's cultural needs.

- As a FQHC, FCHC has a goal to have the board and staff mirror the population that they serve. FCHC has made many changes toward this goal. FCHC now has a leadership team that is very diverse and uses preferred pronouns on all staff name tags. They now require all medical assistants to be bilingual to ensure that they have medical translators on staff. FCHC uses HealthStream to deliver culturally competent trainings and also offer in-house specialized trainings on the needs of certain populations.

- FCHC's assesses for cultural needs and preferences. Assessed needs include assessment of preferred language and questions about gender identify and sexual preferences. A few member files noted the member's religious preferences but there was no evidence that cultural needs are incorporated into member's plan of care.

COMMUNITY LINKAGES

Community Linkages Requirements

In an effort to meaningfully impact SDoH, promote physical and behavioral health integrated care, and assist members in utilizing their Medicaid benefits, community linkage requirements include:

- Implement and enhance contractual relationships or informal partnerships with local community partners. Community Partnerships will meaningfully impact social determinants of health, promote physical and behavioral health integrated care, and facilitate rapid access to care and needed resources.

- Sponsor local community collaborative forums or participate in existing collaborative forums to develop broader understanding and partnerships between health providers and community resource agencies.

- Demonstrate the results of engaging in partnerships, available access for members to various types of medical and non-medical services and observations regarding the potential short-term and long-term impacts on members.

Community Linkages Findings

- FCHC uses the PRAPARE screening tool to assess SDoH in all adult members and the Survey of Well-being of Young Children (SWYC) screening tool for children. The PRAPARE tool

assesses race, education, employment, ethnicity, income, language, housing status and stability, refugee status, transportation, social integration and support, stress, etc. The SWYC tool assesses development, behavior, Autism Spectrum Disorder risk, family context in children ages one through 65 months. The results of these assessments are then recorded in the member's file.

- The Patient Engagement Manager, care coordinator and other service teams attend monthly community collaborative meetings. These community meetings allow attendees to provide updates about local resources available to the community, trainings and other offers of basic needs supports that benefit the community at large.

- Community resources, including BH resources are stored on FCHC's OneNote digital notebook. The list of resources includes the description of the resources as well as some referral forms if they are available from the organizations. This digital notebook is accessible to all agency staff. As knowledge of new resources become available, the notebook is updated by the lead care coordinator or the patient engagement manger. FCHC is in the process of logging all referral sources, including medical referral sources from the medical neighborhood, on the EMR for easier accessibility when completing referrals for members. This process would remove the step of having to open the digital notebook and printing referral forms. In addition to the collection of resources stored internally, FCHC staff are informed about the use of 211.org to access resources for members.

- FCHC reports that community linkage referrals are logged under the care coordinators user log-in and will remain accessible as an open referral until the care coordinator has closed the referral loop. Whether successful or unsuccessful, the care coordinator must document all engagements with the referral source and the member.

- FCHC provided evidence of multiple existing partnerships with a variety of community-based organizations. They range across the spectrum of organizations that meet the comprehensive needs of PCMH+ members. Examples include nutrition, BH, clothing, services for individuals who are elderly, housing supports, Hartford mammogram bus and Hartford colon cancer screening.

MEMBER FILE REVIEW PROCESS

PEs were instructed to provide 30 of the following member files:

- Five files representative of PCMH+ members who have a BH condition and have received care coordination in the review period. PEs are encouraged to select members who have Wellness Recovery Action Plans or other recovery planning tools.

- Five files representative of PCMH+ members who are a Transition Age Youth and have received care coordination in the review period.

- Five files representative of PCMH+ members who are a CYSHCN and have received care coordination in the review period.
- Five files representative of PCMH+ members who the PE identifies as having a disability and have received care coordination in the review period.
- Five files representative of members who have been linked to community resources to address SDoH in the review period.
- Two PCMH+ members who have moved to another provider. If there were zero PCMH+ members who have moved to another provider, the PE was asked to provide two additional members who are either a member with a BH condition or a member with a disability.
- Three members who have refused care coordination services. If there were zero members who have refused care coordination, the PE was asked to provide two additional files for members who have been linked to community resources to address SDoH.

PEs were instructed to include the following in each member file:

- A demographic description or demographic page which should include at a minimum: member name, member ID, date of birth, gender and preferred language.
- A diagnosis list.
- The most recent member assessment, including an assessment of SDoH.
- Most recent plan of care. If assessed cultural needs and preferences are located elsewhere in the member file, copies of this documentation may be provided in addition to the plan of care.
- Care coordination progress notes, including, but not limited to, referrals to community resource agencies that address SDoH for the specified timeframe. PE was asked not to submit physician or practitioner progress notes unless the notes includes coordination with or acknowledgement of care coordination activities.
- Results of most recent BH screening(s).
- Advance care directive for members with BH conditions (if applicable to the member). If declined by the member, progress notes or other evidence may be provided showing the PE’s efforts.
- Copy of Wellness Recovery Action Plans or other recovery tool (if applicable to the member).
- Transition Age Youth transition plan of care (if applicable to the member).

- Evidence of advance care planning discussions or care plans for CYSHCN (if applicable to the member).
- Copies of IEPs or 504 Plans (if applicable to the member). If not able to obtain, progress notes may show the PE's efforts to obtain the documents.
- Other documentation the PE believes is relevant to the review process and demonstrates compliance with PCMH+ requirements.

Reviewers included two Mercer representatives and one DSS representatives who reviewed a total of 28 member files.

MEMBER FILE REVIEW FINDINGS

General Findings

- FCHC submitted 30 files but two files were duplicates.
- At times, FCHC's care coordinator notes were brief and did not consistently reflect follow up. There were some documented efforts of assistance (e.g., helping a member get an electric wheelchair) but these were listed within a nursing note and not labeled as care coordination notes.

Behavioral Health/Physical Health Findings

- FCHC appears to routinely screen for depression using the PHQ-2 and 9. Other screening and evaluation tools used include the Asthma Control Test, Screening, Brief Intervention and Referral to Treatment (SBIRT), Rapid Estimate of Adult Literacy in Medicine – Short Form (REALM-SF), GAD-7, Home environment, Education and employment, Eating, peer-related Activities, Drugs, Sexuality, Suicide/depression, and Safety from injury and violence (HEEADSSS). There was also evidence of tobacco use screening in the member files. There was evidence that when members screen positive for BH concerns, they are referred for an assessment.
- FCHC did not provide evidence of assessing members for the presence of a psychiatric advance care directive nor did they ask members if they have a Wellness Recovery Action Plan or other recovery plan.
- None of the Transition Age Youth files contained care coordination notes. Two of the records contained a section assessing for "Transition to Readiness to Adult Model of Care" but there was no follow up on next steps.

CYSHCN Findings:

- Most of the CYSHCN files did not contain care coordination notes or there was limited follow up. For instance, in one file, the reason for the appointment was listed as needing a letter for incontinence diapers. The APRN indicated she would write a letter and there is brief note that

the letter was faxed. Other files included notes demonstrating attempts to schedule a member for appointments.

Competencies in Care for Members with Disabilities Findings:

- FCHC's files for members with disabilities identified some member need but the notes were often brief and follow up was inconsistent. There were no flags in the member file to indicate that the member had a disability. In one file a member was requesting a letter for an electric wheelchair due to having a leg amputation. The letter was faxed but there was no follow up to determine if he received the chair. Another file identified the need for a nurse to help with activities of daily living and medication and a need for an evaluation for handicap equipment in the apartment, but the file did not contain any follow up notes.

Cultural Competency Findings:

- FCHC's assesses for cultural needs and preferences. Assessed needs include assessment of preferred language and questions about gender identify and sexual preferences. A few member files noted the member's religious preferences. There was no evidence that cultural needs are incorporated into member's plan of care.

- Health literacy is assessed in some files and includes recommendations if members can read low literacy materials or would require illustrations, audio or video tapes or repeated oral instruction.

Community Linkages Findings:

- FCHC uses the PRAPARE tool to screen for SDoH. PRAPARE assesses a member's housing, education, work, legal, social connections, refugee status and other stressors and assigns a score.

MEMBER INTERVIEWS

Member Interview Process

The input of members is key to the success of the PCMH+ program. Interviews with current PCMH+ members and/or designated family representatives focused on the member experience with PCMH+. In particular, interview questions solicited information about the member's experience with PCMH+ care coordination services and overall satisfaction regarding delivery of these services.

The PE selected the assigned PCMH+ member (and/or their representative) to voluntarily participate in an interview designed and requested that priority be given to members who participate on the PCMH+ oversight committee or to members with at least one PCMH+ care coordination contact in the review period. Face-to-face interviews with members were preferred with the understanding that the interview team would accommodate members' schedules during the onsite review and conduct phone interviews if necessary.

Member Interview Findings

The PE arranged two face-to-face interviews with PCMH+ assigned members.

- Both members are recipients of PCMH+ enhanced care coordination interventions, which was confirmed by FCHC.
- Both members sit on the advisory board and expressed their enthusiasm for the board. They believe their voices are heard. They shared examples of suggestions members made and how these suggestions were taken seriously and acted upon. Both appreciated the ability to vote on issues and that items members brought up appeared in the meeting minutes.
- Neither member had any issues accessing medical care. Both gave examples of being referred to specialists, being told about the different sites to access services and having follow-up calls after treatments. One spoke about her cancer and the specialists she was referred to. The members said they do not need to go far to see providers since, “They are all around me because there are so many sites, it is easy to access services.” Home visits are valued and one member mentioned it is also a way for the PE to see which members need food or have other non-medical needs since some might be too embarrassed to admit these issues.
- Both members agreed that their providers show an interest in their care. Both of the members felt comfortable voicing their opinions and/or disagreeing with their provider if needed. One member stated that there is always a manager to talk to if there is an issue and that she can always call the main number to complain.
- The members knew who their care coordinators were and were able to easily connect by phone or visit in person with them when needed. Both members were grateful for the 24-hour urgent care line since it kept them out of the emergency room. Both members appreciated the bilingual staff, since they also spoke Spanish.
- Neither member expressed a need to utilize a community agency but were aware that their care coordinator could help with SDoH needs. Both inform other members about this service.
- The onsite gym excited the members. Both also appreciated the fact that their dietitian incorporated their culture into account when discussing nutrition and food choices. One member stated, “I’m happy with the service I get here,” and mentioned the centers have ample parking. “It is a blessing for me to find this center,” the other member said.

APPENDIX A

FIRST CHOICE HEALTH CENTERS, INC.
RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	FCHC's penetration rate has remained below 1% since the start of Wave 2.	Evaluate PCMH+ enhanced care coordination member penetration rates and formalize procedures and documentation standards to track and increase the number of PCMH+ members engaged in care coordination activities.
Physical Health-Behavioral Health Integration	FCHC is developing processes to document if a member has a psychiatric advance directive and methods to extract this data point for the monthly reports.	Formalize procedures to identify if a member has a psychiatric advance directive and methods to document or store the psychiatric advance directive in the member record. Formalize procedures to report counts of members with psychiatric advance directives on monthly reports.
	FCHC is developing processes to document if a member has a Wellness Recovery Action Plan and methods to extract this data point on the monthly reports. FCHC is currently using a plan of care as their Wellness Recovery Action Plan but it is not recovery-oriented. FCHC recognizes this as an area of growth.	Formalize procedures to collect and store Wellness Recovery Action Plans in member files and report counts of members with Wellness Recovery Action Plans on monthly reports.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
	While FCHC has a policy in place regarding transitioning a youth to an adult provider, has incorporated the American Academy of Pediatrics' recommendations on the age of transition and developed a five question model for Transition Age Youth, the member files for Transition Age Youth did not contain care coordination notes. Two of the records contained a section assessing for "Transition to Readiness to Adult Model of Care" but there was no follow up on next steps.	Formalize procedures to capture care coordination notes and follow up on transition-related needs identified in the five question model.
Children and Youth with Special Health Care Needs	FCHC is developing processes regarding advance care planning with CYSHCN and recognize this an area of growth.	Formalize procedures to define, identify and develop advance directives for CYSHCN.
	Member files for CYSHCN showed a lack of care coordination notes or limited follow up for CYSHCN members.	Formalize procedures to capture care coordination notes and follow up in the member's file.
	FCHC is developing processes regarding the collection of school-related information (e.g., individualized education plans or 504 Plans) but reviewers did not find evidence of school-related information in the member files.	Develop a process to collect school information, including IEPs and 504 Plans where applicable for incorporation into the member's plan of care.
Competencies Caring for Individuals with Disabilities Requirements	FCHC is developing processes to identify and consistently flag members with disabilities in the EMR.	Formalize procedures to report counts of members with disabilities and counts of members who received an adjusted appointment time on the monthly reports.
	FCHC is developing processes to extract data from their EMR in order to report on counts of members with disabilities and counts of members who have received an adjusted appointment time.	Formalize procedures to capture all member's needs, care coordination notes and follow up in the member's file.
	FCHC disability files identified some member needs but the notes were often brief and follow up was inconsistent.	Develop a training plan to train staff on the unique needs of members with disabilities.
Cultural Competency	FCHC is developing a staff training plan pertaining to the unique needs of members with disabilities.	Formalize procedures to incorporate member's cultural needs into the member's plan of care.

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