HEALTH WEALTH CAREER

PCMH+ WAVE 2 COMPLIANCE REVIEW

HARTFORD HEALTHCARE MEDICAL GROUP, INC.

MAY, 2019

State of Connecticut

TABLE OF CONTENTS

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.

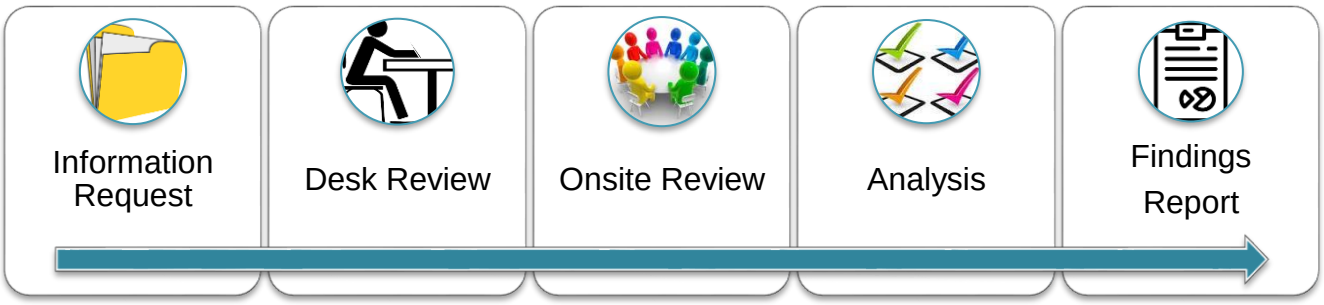
PCMH+ PROGRAM REQUIREMENTS

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 between 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 12, 2019

The onsite review for Hartford Healthcare Medical Group, Inc. (HHCMG) occurred on March 12, 2019 at their 809 Main Street in East Hartford, Connecticut office. The onsite review began with an introductory session with the DSS staff, the Mercer team and HHCMG leadership and PCMH+ dedicated staff. As part of the introduction, HHCMG presented a PCMH+ program implementation overview. Mercer and DSS conducted interviews with HHCMG staff focusing on: PCMH+ Program Operations, Enhanced Care Coordination, Community Linkages and Member Interviews. HHCMG staff interviews included:

- Dianna Caffarena — Vice President of Continuous Improvement
- Nicole Cornell — Director of Care Management
- Janine Forfara — Primary Care Behavioral Health Manager
- Hillary Maynard — Community Resource Coordinator
- Sandra Bernake — Director of Human Centered Care
- Alana Dipesa — Primary Care Behavioral Health Clinician
- Carissa Marin — Manager of Care Management
- Gladys Lopez — Care Coordinator
- Clare Cryar — Care Coordinator
- Priscilla Pandozzi — Care Coordinator
- Colleen Sullivan — Vice President of Care Management
- Mark Dickson — Project Manager
- Roxanne Rotondaro — HHCMG Director
- Susan Barrett — Vice President of Operations, Population Health
- Kelcey Johnson — Patient Experience

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.

2
SUMMARY OF FINDINGS

HARTFORD HEALTHCARE MEDICAL GROUP, INC. PCMH+ PROGRAM OVERVIEW

HHCMG is an Advance Network that has 32 locations across central and eastern Connecticut with PCMH recognition. In addition, five locations are waiting final review and PCMH approval. HHCMG has over 20,000 employees, seven hospitals, 659 primary and specialty care providers, a strong BH network and five Institutes (Bone and Joint, Heart and Vascular, Neuroscience Oncology, Urology and Oncology).

HHCMG PCMH+ staffing includes three full-time employee (FTE) care coordinators and eight BH care coordinators who devote 25% of their time to care coordination for the PCMH+ program. HHCMG contracts with Integrated Care Partners (ICP) for care management services and these individuals take the lead role as the Care Coordinator for PCMH+ members. The three care coordinators are assigned to 12 primary care practices that make up the PCMH+ Advanced Network, and these employees provide full-time care coordination services to the PCMH+ members at these locations. The three care coordinators have a service area of three, four, or five practices which is determined by the size of the patient panels at those locations. The 12 primary care practices have assigned onsite primary care BH clinicians that range from 0.35 FTE to 1.0 FTE.

HHCMG has a senior leader (Susan Barrett) and a clinical director (Dr. Cynthia Heller) who provide oversight and leadership of the PCMH+ program. The senior leader is dedicated to the program 10% of her time and clinical director is dedicated to the program 10% of her time.

HHCMG has an established PCMH+ oversight body that includes 10-15 members, including one PCMH+ voting member. Two PCMH+ providers participate in the oversight body and one of the providers serves as the co-chair of the committee. Meetings have occurred monthly and utilize a standard meeting agenda that incorporates member experience/stories, prevention of underservice, complaints/grievances and operational report outs of quality and PCMH+ activities. There has been limited member representation/ongoing participation in the PCMH+ Oversight Committee, but HHCMG is taking active and creative steps to identify additional PCMH+ members. Most recently, HHCMG utilized a “virtual focus group” and surveyed 2,500 PCMH+ members to capture feedback on SDoH, access to services, mental health, legal concerns, transportation and discrimination.

HHCMG provides care coordination for 4,084 PCMH+ members. HHCMG reports an average penetration rate of 3.2%. 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, HHCMG has reported the following unique member contacts per month: June 2018 - 0 members; July 2018 - 0 members; August 2018 - 0 members; September 2018 - 157 members; October 2018 - 98 members; November 2018 - 99 members; December 2018 - 87 members and January 2019 - 129 members. HHCMG care coordinators average 13.45 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	Although there has been limited PCMH+ member representation/ongoing participation in the PCMH+ Oversight Committee, HHCMG is taking active and creative steps to identify additional PCMH+ members, encourage a broader participation, and obtain member feedback through virtual focus groups and 1:1 interviews with members at a location of their choice.
	HHCMG utilizes one electronic medical record (EMR), Epic®, that provides HHCMG with a strong platform to deliver coordinated care. In addition to Epic®, Care Everywhere is utilized by providers, which provides information about services utilized by members outside of HHCMG.
	HHCMG contracts with ICP for care management services and these individuals take the lead role as the care coordinator for PCMH+ members. ICP is fully integrated into the HHCMG system and the care coordinators demonstrate strong care coordination practices for PCMH+ members.
	HHCMG consistently demonstrated a penetration rate of 3.2%. HHCMG employs 11 care coordinators and averages 188 care coordination contacts per month, which calculates to 13.45 member contacts per month for each care coordinator.
	The member assessment and care coordination notes follow a designated template that ensures standardized documentation on upcoming appointments, medications, advanced directives and assessment questions such as living arrangements, support systems, type of residence, financial problems, transportation issues and means, nutrition adequacy.
Physical Health-Behavioral Health Integration	Universal BH screening is conducted for all members. Utilized BH screenings include the Patient Health Questionnaire (PHQ-9), General Anxiety Disorder 7- item (GAD-7) and CAGE (substance abuse screening tool).
	Care coordinators are required to complete Mental Health First Aid trainings. Additionally, all clinicians are trained in Zero Suicide and utilize TigerText, a Health Insurance Portability & Accountability Act (HIPAA) compliant messaging system.
Competencies in Care for Individuals with Disabilities	HHCMG utilizes a tool in Epic® with a set of diagnoses to identify members with disabilities and has multiple processes in place to identify members who may require an adjusted appointment time or communication supports.

REVIEW AREA	STRENGTH
	Disability competency training is comprehensive and covers definitions, removing barriers to disabilities, disability awareness and etiquette, the Americans with Disabilities Act, abuse, neglect and exploitation of disabled persons and community resources.
Cultural Competency	Cultural competency training is comprehensive and covers a variety of topics including definition of culture and cultural competence, unconscious bias and impact, the impact of culture on healthcare, Culturally and Linguistically Appropriate Services (CLAS) and basics of providing culturally competent care.
	It was evident that care coordinators ask members about their culture and about specific needs or preferences the member has related to their culture.
	HHCMG has two bilingual Spanish-speaking care coordinators to speak and assist with the Spanish speaking population.
Community Linkages	Although a standardized SDoH screening tool is under development, care coordinators assess for living arrangements, support systems, family conflict, presence of domestic violence, financial problems, transportation needs and use of alcohol and tobacco needs.
	Within Epic®, HHCMG will be implementing Aunt Bertha, a comprehensive community resource directory which allows for bidirectional communication between community-based organizations and the referring entity.

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 posed challenges for many of the PEs and therefore, the challenges identified at this PE are not unique. DSS recognizes that the definition for this population varies 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 this specialty population.

REVIEW AREA	OPPORTUNITY
Program Operations	Five of HHCMG’s sites are pending PCMH recognition. After these sites receive recognition, 100% of HHCMG’s sites will have achieved PCMH recognition.
	The quality program does not address how the PCMH+ program is evaluated and contributes to the HHCMG quality goals.
Physical Health-Behavioral Health Integration	HHCMG is in the process of standardizing the BH screening approach for children and adolescents, including use of CRAFFT (substance abuse screening tool for use with children under the age 21).

REVIEW AREA	OPPORTUNITY
	HHCMG is continuing to develop and utilize a longitudinal plan of care that includes member's physical, behavioral and non-medical support services.

3
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

- HHCMG has 32 locations that have obtained PCMH recognition through NCQA. In addition, five sites are in the process of submitting required documentation to obtain recognition. Final virtual review was scheduled for March 1, 2019. After the review and approval, 100% of primary care sites will have received PCMH recognition.
- HHCMG has an established oversight body that includes 10-15 members, including one PCMH+ voting member. Meetings typically occur monthly and in January 2019, a “virtual focus group” was held through a patient survey, which was administered to 2,500 PCMH+ members to capture feedback on SDoH, access to services, mental health, legal concerns, transportation and discrimination. Seventy-two responses were received and among most notable key findings were the fact that over half of respondents reported not being asked about SDoH at their last primary care visit and over 90% of respondents said that transportation was not a factor preventing them from getting to medical appointments. Survey results were analyzed and shared with the PCMH+ Oversight Committee. Due to challenges with recruiting members for participation in the oversight body meetings, HHCMG will continue to utilize “virtual focus groups”, conduct individual interviews with PCMH+ members at a location of their choice, offer transportation to allow members to attend the meetings and provide phone cards so members can participate via telephone.

- HHCMG has a Population Health/Quality Care Council charter that outlines the infrastructure for managing and prioritizing quality of care measures including PCMH+ measures and reporting processes. Included in the charter are milestones such as implementation of Aunt Bertha in Epic®, a referral resource platform; developing and implementing a pediatric developmental screening tool in Epic®; developing and implementing a pediatric and adolescent behavioral health screening tool in Epic®; expanding race and ethnicity in Epic®, implementing a SDoH screening tool in Epic®; and developing and implementing asthma best practices.

- HHCMG has identified a senior leader (Susan Barrett) and a clinical director (Dr. Cynthia Heller) to provide oversight and leadership for the PCMH+ program. The senior leader is dedicated to the program 10% of her time and clinical director is dedicated to the program 10% of her time.

- HHCMG employs three FTE care coordinators and eight behavioral health care coordinators who devote 25% of their time to care coordination. HHCMG contracts with ICP for care management services and these individuals take the lead role as the care coordinator for PCMH+ members. The three care coordinators are assigned to 12 primary care practices that make up the PCMH+ Advanced Network, and these employees provide full-time care coordination services to the PCMH+ attributed members at these locations. The three care coordinators have a service area of three, four, or five practices which is determined by the size of the patient panels at those locations. The 12 primary care practices have assigned onsite primary care behavioral health clinicians that range from 0.35 FTE to 1.0 FTE.

- Care coordination contacts are tracked on a daily basis within HHCMG's EMR, Epic®. The PCMH+ care coordinators use specific topics linked to their documentation which is then reported out automatically to leadership. For the systems/providers that also use Epic®, HHCMG utilizes "Care Everywhere" that provides information about services members receive outside of HHCMG. HHCMG also utilizes flow sheets that capture longitudinal information of a member.

- PCMH+ care coordinators receive weekly group supervision by the manager and director of the ICP Community Care Management team and care coordinators have the opportunity for individual supervision for more challenging cases. In addition, care coordinators participate in daily huddles and monthly grand rounds. Leadership utilizes weekly reporting from Epic® along with clinical audits to oversee the quality of the care coordination services. Care coordination vacancies are back filled by other existing ICP care management resources.

- HHCMG consistently submits the PCMH+ monthly report on a timely basis each month.

- On average, HHCMG reports a penetration rate of 3.2%. HHCMG care coordinators average 13.45 care coordination contacts per month.

- *Note: HHCMG reports they will provide further details on available PCMH+ program. Policies and Procedures not already included in the desk review submission by July 1, 2019.*

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

- HHCMG applies a comprehensive under-service methodology to monitor, identify and address underservices. HHCMG has a range of policies in place for managing patients that do not show up for appointments, notification procedures if a patient missed an appointment, no show/same day cancelation documentation procedures, and guidelines for releasing/discharging a patient from a provider and/or HHCMG.

- HHCMG revised the patient discharge process to incorporate patient counseling prior to discharge to help identify root causes of non-compliance and gives the patient the opportunity to rectify the situation.

- HHCMG monitors member complaints and patient discharges monthly and quarterly.

- 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

- HHCMG utilizes several BH screenings, including the PHQ-9, GAD-7 and CAGE. Per the member file review, there was evidence for screening beyond depression and anxiety, including screening for substance use disorders (SUDs). When screenings were completed with adolescent members, the PHQ-2 was utilized. During the onsite review, HHCMG reported plans for standardizing BH screening for children and adolescents including using CRAFFT (a substance abuse screening tool for use with children under the age of 21). HHCMG provided evidence of utilizing the General Practitioner Assessment of Cognition (GP-COG) which assesses for cognitive impairment and the Mini-Mental State Exam (MMSE) which assesses for issues with memory and other cognitive functions. HHCMG also provided evidence in the member file reviews that BH screening is conducted with all members and consistently provides counts of members screened for BH in the monthly reports.
- HHCMG conducts universal BH screenings. Members are screened with the PHQ-2 and GAD-2 during every physical exam with the primary care provider (PCP). If a member screens positive on the PHQ-2, then the PHQ-9 is automatically administered, documented in the member's chart and a referral to BH is made. PCPs also utilize the Alcohol Use Disorders Identification Test (AUDIT-C) and if positive, a referral to BH is made. If the member agrees to engage in services, the PCP introduces the member to the embedded BH clinician at the time on the onsite visit through a warm hand-off.
- For members already enrolled in BH, HHCMG documents existing services in the clinical record and notes coordination with BH providers. The PCP is copied on the screenings. When a member screens positive on a BH screen, there is evidence that the member is referred to BH

for follow-up. For pediatric members with BH conditions, there was reference to the member's BH needs in the care coordinators' notes.

- HHCMG is in the process of developing a longitudinal plan of care that includes member's physical, behavioral and non-medical support services.
- PCMH+ care coordinators are required to complete annual Mental Health First Aid trainings which is considered a best practice. All clinicians are trained in Zero Suicide and utilize "TigerText," a HIPAA compliant messaging system.
- HHCMG has processes in place to obtain and maintain copies of psychiatric advance directives and Wellness Recovery Action Plans for BH members. Per the member file review, there was consistent evidence of inquiring about the presence of Wellness Recovery Action Plans and psychiatric advance directives. Per the monthly report, three psychiatric advance directives were collected, reviewed and placed in the member's record. HHCMG did not report quarterly counts for the number of Wellness Recovery Action Plans obtained and a copy maintained in the member's record. For those members who indicated an interest in developing these BH tools or were referred to BH to inquire further, there was evidence of follow-up.
- HHCMG has established a definition of Transition Age Youth as individuals between ages 12 to 25 years that are aging in or out of services. HHCMG has a registry in Epic® that identifies these individuals. Per the monthly report, HHCMG identified 505 Transition Age Youth.
- For Transition Age Youth, care coordinators inquire about advance directives, but transition planning was not evident in the member files because no members have expressed an interest in developing an advance directive.

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

- During the onsite review, HHCMG reported serving a small pediatric population, of which CYSHCN comprise an even smaller number. Per the monthly report, HHCMG has only identified 29 CYSHCN. Children are typically served by pediatricians and specialists outside of HHCMG.

- Each pediatric PCMH+ member who receives outreach from either a care coordinator or embedded BH clinician also receives standardized screening for advance care planning needs.

- If an advanced care directive has been developed outside of the organization, the standard screening includes a request for a copy of the document that is scanned into the member's electronic medical record. In the future, this screening will occur during annual visits to the PCP as well.

- If a member was identified with a need for collaboration with school based personnel, the process includes assessment with the member and family/caregiver, obtaining written consent for communication from the responsible party for two-way communication with school based staff, incorporation of findings into care coordination, and scanning of IEPs or 504 Plans into electronic medical record. Per the member file review, HHCMG provided evidence of coordination and communication with the child's school for CYSHCN, with other providers or community resources involved with the member.

- Per the member file review, for pediatric members, HHCMG assesses for the presence of an IEP and/or 504 Plan. HHCMG notes that families often will not provide a copy of either the IEP or the 504. When an IEP or 504 Plan is in place, the families were instructed to submit the plan to the PCP at the next visit. Records indicated that there was follow-up regarding obtaining documents and inquiring about issues at school.

- *Note: HHCMG reports they will share details on CYSHCN advance care planning policies and procedures P&Ps by July 1, 2019.*

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

- For members with disabilities, care coordinators assess for adaptive supports and home health needs. Follow-up occurs to ensure that the member receives the supports needed. Additionally, the needs of members with disabilities were consistently included in plans of care.
- The scheduling system allows HHCMG to predetermine patients who may require additional time for an appointment. Patients with additional needs are identified by the provider who then documents a visit modifier on the schedule in the electronic medical record. Members and care coordinators can also identify adjusted appointment times or communication supports.
- HHCMG consistently reports on the number of members with disabilities who have received an adjusted appointment time.
- A comprehensive disability competency training is required to be completed by April 1, 2019 for all new and existing staff and providers of the 12 practices in the network. The disability competency training covers definitions, removing barriers to disabilities, disability awareness and etiquette, the Americans with Disabilities Act, abuse, neglect and exploitation of disabled persons and community resources.
- All new construction medical facilities within HHCMG are compatible for individuals with physical disabilities. Service animals are allowed and American Sign Language (ASL) interpretation services are available through a partner agency. All provider site assessments include a quality assessment and address any physical needs such as a ramp, high/low exam table, bariatric scales, etc.
- HHCMG utilizes a tool in Epic® with a set of diagnoses to identify members with disabilities and consistently reports on the number of members with disabilities on the monthly report.

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

- All staff receive cultural competence introductory training during new hire orientation. A cultural competency training is required to be completed by April 1, 2019 for all new and existing staff and providers of the 12 practices within the network. The comprehensive training is hosted in the e-learning platform and covers a variety of topics including the definition of culture and cultural competence, unconscious bias and impact, the impact of culture on healthcare, CLAS and basics of providing culturally competent care.
- During outreach to a member, the care coordinator performs a general care management assessment and asks about their culture and inquires about specific needs or preferences the member has related to their culture. Per the member file review, it was evident that the SDoH assessment assesses for cultural needs by asking if the individual has beliefs that impact treatment and the preferred language can be found in the member's demographic page.
- Cultural competency training includes a section on CLAS. HHCMG has a standard work process for providing language assistance to patients. Interpreter services are available to patients for every visit through use of the language line telephone interpretation service.
- Two out of three assigned PCMH+ care coordinators are fluent in Spanish.
- Interpreters and Translators, Inc. (iTi) is utilized as the HHCMG's certified language line for telephonic, video and in-person translation needs, including ASL.

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

- HHCMG has staff from the Preventive Medicine Initiative and Community Relations Department who attend and participate in Wallingford Community Resource Alliance, the Healthcare Committee of the Greater Norwich Chamber of Commerce, and the Eastern Connecticut Health Collaborative. HHCMG hired a Community Resource Coordinator in November 2018 who participates with these organizations and leverages previously built relationships to increase the number of resources including community based organizations.

- A community resource directory is housed and shared on a secure website and is updated annually. In the future, HHCMG and ICP intend to integrate a national community resource directory, Aunt Bertha, within Epic®. Patients, providers, and care coordinators will be able to identify available community-based organizations and resources by topic and zip code. Aunt Bertha also allows for bidirectional communication between HHCMG and community-based organizations which allows for tracking of outcomes and completion of referrals.

- HHCMG has 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. Partnerships include, but are not limited to: BH organizations, aging services, domestic violence, home care support agencies, transportation/senior centers/meals on wheels, nutrition, basic needs/energy assistance, housing support, etc. There are an additional 25 organizations pending approval in the first quarter of 2019.

- PCMH+ care coordinators screen each patient with whom they have a contact for SDoH needs. The referrals are completed within the EMR. The care coordinator manually places referrals by calling the agencies and providing necessary information and members are provided with options in the area to choose from.

- Although there is not a standard SDoH screening tool, the care coordinator utilizes a care management assessment which includes questions pertaining to SDoH. Elements addressed include: Living arrangement, support systems, family conflict, presence of domestic violence, financial problems, transportation needs and use of alcohol and tobacco products. There is a system-wide SDoH screening tool and intervention workgroup that will develop and implement a standard SDoH screening tool across the care continuum. Implementation of the SDoH screening tool in Epic® is targeted for summer/fall of 2019.

- Per the member file review, it was evident that care coordinators follow through on linkages to community resources and help to ensure that the individual's needs are meet. Needs are documented in notes and flow sheets. In one example, the care coordinator provided detailed and ongoing notes indicating efforts to address and follow-up on the members identified SDoH needs. In some cases, the care coordinator documents the community resources utilized by the member in the clinical notes and any upcoming appointments with those providers.

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.

MEMBER FILE REVIEW FINDINGS

General Findings

- Reviewers included two Mercer representatives and one DSS representatives who reviewed a total of 30 member files.
- The assessment and care coordination notes appeared to follow a designated template that ensured documentation on upcoming appointments, medications, advanced directives and assessment questions such as living arrangements, support systems, type of residence, financial problems, transportation issues and means, nutrition adequacy.
- One record contained 27 care coordination entries in which the care coordinator demonstrated an understanding of the members' struggles. This member had severe PH issues that could be life threatening, including non-compliance with insulin, no running water and heat at his home and cultural beliefs that may be contraindicated for the needed care.

Behavioral Health/Physical Health Findings

- HHCMG utilizes several BH screenings, including the PHQ-9 and GAD-7. There was evidence of screening beyond depression and anxiety, including screening for SUDs. When screenings were completed with adolescent members, the PHQ-2 was utilized. HHCMG provided evidence

of utilizing the GP-COG which assesses for cognitive impairment and the MMSE which assesses for issues with memory and other cognitive functions.

- For members already enrolled in BH, HHCMG documents existing services in the clinical records and sometimes notes coordination with BH providers. The PCP is copied on the screenings. When a member screens positive on a BH screen, there is evidence that the member is referred to BH for follow-up. For pediatric members with BH conditions, there was reference to the member's BH needs in the care coordinators' notes. All staff has access to this information in Epic®.

- For BH members, there is evidence of inquiring about the presence of Wellness Recovery Action Plan and psychiatric advance directive. For those members who indicated an interest in developing these BH tools or were referred to BH to inquire further, there was also evidence of follow-up. The Wellness Recovery Action Plan is easily accessible with a click.

- For Transition Age Youth, care coordinators inquire about advance directives, but transition planning was not evident in the member files because no members have expressed an interest in developing an advance directive. It is unclear if the advance directive inquiry includes psychiatric advance directives for members with BH conditions.

Children and Youth with Special Health Care Needs Findings

- For pediatric members, HHCMG assesses for the presence of an IEP and/or 504 Plan. HHCMG notes that families often will not provide a copy of either the IEP or the 504. When an IEP or 504 Plan is in place, the families were instructed to submit the plan to the PCP at the next visit. Records indicated that there was follow-up regarding obtaining the documents and inquiring about school issues.

- HHCMG provided evidence of coordination and communication with the child's school for CYSHCN, with other providers or community resources involved with the member.

Competencies in Care for Members with Disabilities Findings

- For members with disabilities, care coordinators assess for adaptive supports and home health needs. Follow-up occurs to ensure that the member receives the supports needed. Additionally, the needs of members with disabilities were consistently included in plans of care.

Cultural Competency Findings

- The SDoH assessment assesses for cultural needs by asking if the individual has beliefs that impact treatment and the preferred language can be found on the member's demographic page.

Community Linkages Findings

- HHCMG utilizes a care management assessment which includes questions pertaining to SDoH. Elements assessed include: Living arrangement, support systems, family conflict, presence of domestic violence, financial problems, transportation needs and use of alcohol and tobacco products.

- Care coordinators follow-through on linkages to community resources and help to ensure that the individual's needs are meet. Needs are noted in notes and in flow sheets. In one example, the care coordinator provided detailed and ongoing notes indicating efforts to address and follow-up on the members identified SDoH needs. Care coordinator documents the community resources utilized by the member in the clinical notes and any upcoming appointments with those providers.

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 one face-to-face interview with PCMH+ assigned member[1]:

- The member was not receiving care coordination interventions but did state that her PCP referred her to a therapist/counselor in the office who she sees regularly.

- The member sits on the advisory board and is delighted and "impressed with the number of people involved in the meetings every month and the investment that HHCMG is making in the care of their members." The member states that she sees a "genuine passion from HHCMG to make their services available and comfortable for everyone." The member feels that her voice is heard and valued in this forum.

- The member did not have any issues accessing medical care. The member feels that her provider shows an interest in her care. She feels very comfortable voicing her opinion and/or disagreeing with her provider if needed. The member felt that if she had a complaint she would let her PCP know and it would be handled.

[1] The PE identified two additional PCMH+ assigned members to participate in interviews, but the members were unavailable on the day of the scheduled onsite review.

- The member had mentioned that she had lower back pain previously and mentioned it immediately to her PCP. Her PCP helped her find a specialist that worked with her insurance and also followed up by calling her at home to make sure she liked the doctor he suggested. The member stated that she “loves the way he cares about his patients.”
- The member has not needed to be connected with a community organization but knows that there is information in the PCP’s office on SDoH. Her therapist/counselor has also mentioned other resources online to help her find support while taking care of her disabled husband. Between the member’s PCP and therapist, she feels very supported.
- The member stated that “she thinks it’s important for people to know everybody’s coming together to try to make their health care better. I wish we could tell everyone about HHCMG and the work being done. I tell all of my friends.”

APPENDIX A

HARTFORD HEALTHCARE MEDICAL GROUP, INC. RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	Five of HHCMG's sites are pending PCMH recognition. All sites are expected to achieve recognition by March 2019.	Provide an update to DSS on the status of PCMH recognition for sites pending recognition.
	The quality program does not address how the PCMH+ program is evaluated and contributes to the HHCMG quality goals.	HHCMG is encouraged to include the PCMH+ program and evaluation efforts in the quality plan.
Physical Health-Behavioral Health Integration	HHCMG is in the process of standardizing the BH screening approach for children and adolescents, including use of CRAFFT (substance abuse screening tool for use with children under the age 21).	Formalize procedures to standardizing BH screening approach for children and adolescents.
	HHCMG is continuing to develop and utilize a longitudinal plan of care that includes member's physical, behavioral and non-medical support services.	Finalize procedures for development and utilization of a longitudinal plan of care that includes member's physical, behavioral and non-medical support services.

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