HEALTH WEALTH CAREER

PCMH+ WAVE 2 COMPLIANCE REVIEW

PROSPECT CT MEDICAL FOUNDATION

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 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 26, 2019

The onsite review for Prospect CT Medical Foundation (PCTMF) took place on March 26, 2019 at 64 Robbins Street, Waterbury, Connecticut. The onsite review began with an introductory session with the DSS staff, the Mercer team and PCTMF leadership and PCMH+ dedicated staff. As part of the introduction, PCTMF presented a PCMH+ program implementation overview. Mercer and DSS conducted interviews with PCTMF staff focusing on: PCMH+ Program Operations, Enhanced Care Coordination, Community Linkages and Member Interviews. PCTMF staff interviews included:

- Kathryn Ruszcsyk – Director, Healthcare Services
- Ed Roberts – Executive Director, CRC
- Garry Bliss – Project Director
- Caitlyn Palmer – Manager, Care Management
- Sara Linskey – MSW Care Manager
- Nancy Petso – RN Care Manager
- Erin Galluce – RN Care Manager
- Terrie Vetrano – RN Community Nurse Care Manager
- Stefanie Windsor – Care Coordinator

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 are the basis for this report.

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SUMMARY OF FINDINGS

PROSPECT CT MEDICAL FOUNDATION PCMH+ PROGRAM OVERVIEW

PCTMF is an advance network serving two regions: The greater Waterbury region and the Eastern Connecticut region. The greater Waterbury region includes the Waterbury Hospital system, Alliance Medical Group (medical group of 37 primary care providers and 88 specialists), Child and Adolescent Health Care Associates (pediatric primary care group with five providers) and other provider practices. Waterbury Hospital is a Level II Trauma Center providing cardiac care, cardiac catheterization laboratory, BH and substance use services, emergency and observation, stroke center care, cancer center care, obstetrics and gynecology, orthopedic and neurology services. The Eastern Connecticut region includes the Eastern Connecticut Health Network with Manchester Memorial Hospital and Rockville General Hospital, Eastern CT Medical Professionals (34 primary care providers and 145 specialists) and other provider practices. Both hospital systems offer emergency psychiatric services, adult and adolescent BH services and inpatient BH care. PCTMF serves a small pediatric population of approximately 283 children. Most are seen at the Chase Clinic and Rockville Family Practice.

PCTMF staffing includes 14 full-time care coordinators who are dedicated full-time to the program; with one of the fourteen care coordinators dedicated to behavioral health care coordination (a community health worker). One community health worker care coordinator position is currently vacant. Recruitment efforts are underway to fill this position. PCTMF utilizes a pod approach for team members assigned to each hospital system. Each pod is comprised of an inpatient care manager, a post-acute care manager, a transitional care nurse, a high intensity care manager, a care coordinator and a community health worker. A medical social worker is also assigned to assist with social service referrals, outreach and consults. Staff are cross-trained to allow for cross-coverage during staff vacancies.

PCTMF has identified two senior leaders (Ed Roberts and Gary Bliss) and a clinical director (Kathryn Ruszczyk) to provide oversight and leadership of the PCMH+ program. PCTMF's has a strong leadership team who is passionate about the PCMH+ program and dedicated to fulfilling the vision and mission of the program.

PCTMF provides care coordination for 8,455 PCMH+ members. PCTMF 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,

PCTMF has reported the following unique member contacts per month: June 2018: zero members; July 2018: zero members; August 2018: seven members; September 2018: 21 members; October 2018: 14 members; November 2018: 13 members; December 2018: 50 members and January 2019: 54 members. PCTMF's care coordinators average less than 2 care coordination contacts per month. It is important to note that a ramp-up period is typical for newly implemented programs.

PCTMF is using multiple electronic medical records (EMRs) across multiple hospital systems, behavioral, and physical health providers. Care plans are housed in an independent case management software called Essette which is not integrated with the various EMRs. Lack of a cohesive, integrated electronic health network raises significant challenges for care coordination delivery, sharing of member information and monitoring of the PCMH+ program. PCTMF has plans to move to a population-based software program in approximately two-years.

STRENGTHS

REVIEW AREA	STRENGTH
Program Operations	PCTMF has a strong leadership team who is passionate about the PCMH+ program and dedicated to fulfilling the vision and mission of the program.
Physical Health-Behavioral Health Integration	As part of the onboarding process, staff are required to complete Mental Health First Aid trainings which is considered a best practice. Staff are also trained on the BH referral process that must be followed if a member screens positive on a BH screen.
Cultural Competency	PCTMF staff receive cultural competency training during the onboarding process and annually thereafter.
Community Linkages	PCTMF has implemented a phased strategy to address SDoH. Phase 1 includes engaging members to assess for SDoH, Phase 2 includes staff training on the impact of SDoH and Phase 3 includes the standardization of processes to support a consistent approach to implement and assess impact and progress. Phase 3 also includes embedding SDoH questions into the EMR, educating remaining staff and developing reports to assess progress.
	As part of the onboarding process, PCTMF staff are provided member education resources, including referral resources for community linkages that address SDoH.
	PCTMF has established multiple partnerships with a variety of community-based organizations. They range across the spectrum of organizations that meet the comprehensive needs of PCMH+ members.
	PCTMF care coordinators use a transitional care management (TCM) progress note template which includes prompts for SDoH.

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.

REVIEW AREA	OPPORTUNITIES
Program Operations	PCTMF is using multiple EMRs across hospital systems, BH providers, PH providers and care coordination documentation is not currently integrated into the EMRs. Care coordinators only have access to certain parts of the medical record and care coordination notes are faxed to providers. Care plans are housed in an independent case management software called Essette.
	Five newly acquired practices do not hold PCMH recognition. A work plan is being developed to bring these practices under PCMH recognition by 2020.
	PCTMF will not hold their first oversight body meeting until April 2019.
	PCTMF has demonstrated a low penetration rate of less than 1%.
	PCTMF's current care management workflow limits care coordination to high-risk patient transitions of care from the acute hospital to home, or skilled nursing facility to home, direct provider referrals or by risk stratification data. This current model of care may be contributing to a high rate of members declining care coordination services and/or the low penetration rate.
	PCTMF's monthly report contains inaccurate information and is not completed in its entirety.
	PCTMF is developing a quality program plan to fully implement PCMH+ quality requirements.
Under-Service	PCTMF does not have an under-service policy or methodology that monitors for, identifies, and addresses under-service and access to medically necessary care.
Physical Health-Behavioral Health Integration	BH and PH EMRs are completely separate and member information is not shared bi-directionally between behavioral and medical providers. PCTMF is researching system integration methods to improve care coordination efforts.
	Based on the member file review, there was no evidence that PCTMF develops plans of care for members with BH conditions. Files for BH members contained limited care coordination notes and did not demonstrate coordination between BH and PH providers.
	PCTMF is developing a universal BH screening process.
	PCTMF is developing a process to assess members with advanced psychiatric directives and inclusion of directives in the member file.
	PCTMF is developing processes to assess members with wellness recovery action plans and inclusion of the plan in the member file.
	PCTMF is developing processes to query multiple EMRs to meet the monthly PCMH+ reporting requirement on the number of psychiatric advance directives and Wellness Recovery Action Plans conducted and/or collected on PCMH+ members.
	PCTMF is developing processes to meet Transition Age Youth program requirements.

REVIEW AREA	OPPORTUNITIES
Children and Youth with Special Healthcare Needs	PCTMF is developing processes to meet CYSHCN program requirements.
	PCTMF is developing processes to track and extract the number of individualized education plans (IEPs) and 504 Plans collected from the EMR for the monthly report.
Competencies Caring for Individuals with Disabilities	PCTMF is developing processes to address the needs of members with disabilities as a specialty population under the PCMH+ program.
	PCTMF's definition of members with disabilities is limited to members with the presence of certain Diagnosis Related Group (DRG) medical codes. This may be limiting the number of members with disabilities identified for care coordination services.
	PCTMF is developing processes to track and extract the number of members who have received adjusted appointment times from the EMR for the monthly report.
	PCTMF is developing standardized documentation procedures regarding the unique needs of members with disabilities.
	PCTMF has not yet implemented mandatory staff disability competency trainings
	PCTMF is exploring options to offer written materials in braille and large print for members with visual impairments.
Cultural Competency	PCTMF is developing processes to assess members for cultural needs and preferences.
	PCTMF is developing processes to incorporate member cultural needs and preferences in the plans of care.
	PCTMF has not integrated culturally and linguistically appropriate services (CLAS) into the organization.
Community Linkages	PCTMF does not screen all members for SDoH.
	PCTMF does not have a standardized documentation process to demonstrate that community health workers work with members to resolve SDoH.

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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

- PCTMF reports five newly acquired practices do not currently hold PCMH recognition. A work plan is under development to bring these practices under PCMH recognition by 2020 (based on the NCQA 2017 standards).
- PCTMF reports the first oversight body meeting is scheduled for April 17, 2019 and expects 3-4 PCMH+ members and/or family members in attendance. PCTMF sent oversite body recruitment letters to PCMH+ members who have previous been engaged in care coordination services. Skype dial-in will be made available to members who are unable to attend in-person.
- PCTMF has identified two senior leaders (Ed Roberts and Gary Bliss) and a clinical director (Kathryn Ruszczyk) who provide oversight and leadership for the PCMH+ program.
- PCTMF has care coordination staff of 14: 13 FTE care coordinators and one FTE BH care coordinator (a community health worker). One community health worker care coordinator position is currently vacant. Recruitment efforts are underway to fill this position. PCTMF's staffing model appears to be sufficient for the volume of PCMH+ members assigned.
- PCTMF is assigned 8,455 PCMH+ members. On average, PCTMF reports a 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. PCTMF's care coordinators average less than 2 care coordination contacts per month.

- PCTMF is developing care management (care coordination) workflows on high-risk patient transitions of care from the acute hospital to home, or skilled nursing facility to home, direct provider referrals or by risk stratification data. All member files provided by PCTMF were for members with recent hospitalizations. Most members receive three calls as required of the community health workers and assistance is primarily limited to the scope of these calls. Those members who demonstrate an ongoing need for medical or social work case management are enrolled in community care management programs. Member files did not provide evidence of ongoing care. PCTMF has a high rate of members declining or refusing care coordination (as high as 45 members per month). PCTMF's current model of care may be contributing to low penetration rates.

- PCTMF submits required PCMH+ monthly reports to the Department. Reports were incomplete and contained inaccurate information for the months pending a fully executed contract with the Department (May to December 2018) An executed contract is now in place yet PCTMF's report continues to contains inaccurate information regarding to the oversight body.

- PCTMF is using multiple EMRs across hospital systems and providers. Waterbury uses Cerner, ECHN uses Meditech and providers use Allscripts but different versions. Care coordination documentation is not currently integrated into the EMRs and care coordinators are not able to fully access all aspects of the medical records. Care coordination notes are faxed to providers, and care plans are housed in an internal case management software called Essette. The use of multiple EMRs and the inability for all clinical team members to access the EMR creates significant challenges for implementation, sharing of member information and monitoring of the PCMH+ program. PCTMF plans to move to a population-based software program in approximately two years.

- PCTMF is developing a quality program plan to address PCMH+ quality requirements.

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

- PCTMF does not currently have an underservice policy or methodology that identifies, monitors for and addresses underservice utilization or inappropriate reductions in access to medically necessary care.

- 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

- Staff are required to complete Mental Health First Aid trainings which is considered a best practice. Staff are also trained on the BH referral process that must be followed if a member screens positive on a BH screen.

- PCMTF has policies in place for "warm hand-offs" when a member screens positive for a BH condition. PCTMF has assigned an APRN (Regina) who is specifically trained in BH integration activities at the Chase Clinic, a primary care setting. She directly handles the warm hand-off between PH and BH providers. Another LPN at the Clinic serves as Regina's back-up when she is not available.

- BH and PH EMRs are completely separate and member information is not shared bi-directionally between behavioral and medical providers. PCTMF is researching system integration methods to improve care coordination efforts.

- Based on a member file review, there was no evidence of care plans for members with BH conditions. Files for BH members contained limited care coordination notes and did not demonstrate coordination between BH and PH providers.

- Currently, PCTMF reports screening members annually using the PHQ-2/9 and has plans to develop a more robust BH screening process. PCTMF provided draft policies and procedures which indicated plans to use additional screening tools such as the Generalized Anxiety Disorder – 7 item (GAD-7), CAGE-AID and the Suicide Assessment. Staff are trained on the use of these tools. PCTMF also reports they are considering the use of a patient self-assessment via a tablet, which can be uploaded directly into the Primary Care Physician medical record. The member file review did not contain evidence of universal BH screenings. There was some evidence of assessment for alcohol and substance use in the social section of the ECHN files but no demonstration of identifying potential misuse or referrals. The patient manager section of some charts contained evidence of PHQ-9 screening. PCTMF reports that screenings have not always been incorporated in the EMR but they are in process of standardizing documentation requirements.

- PCTMF has policies in place regarding psychiatric advance directives and Wellness Recovery Action Plans. However, policies are vague and no member file contained evidence of psychiatric advance directives, Wellness Recovery Action Plans or an inquiry process to determine if members had existing plans. PCTMF has not reported on the number of psychiatric advance directives and Wellness Recovery Action Plans on the monthly PCMH+ reports and indicated their EMRs do not have the ability to track or extract this data.

- PCTMF is developing processes to address the needs of Transition Age Youth as a specialty population under the PCMH+ program. PCTMF did not submit any documents describing their work with Transition Age Youth and did not submit any Transition Age Youth files for review. PCTMF began reporting the number of Transition Age Youth in January 2019, defining Transition Age Youth ages 12-21 years with office visits.

- PCTMF began reporting on the number of members with BH conditions in January 2019 and defined members with BH Conditions as members with the presence of DRG visit history codes

inclusive of: F32 (depression), F41(anxiety), F90 (ADHA), F98 (ADD), R46 (behavioral disorder) and F48 (mental disorder).

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

- PCTMF is developing processes to address the needs of CYSHCN as a specialty population under the PCMH+ program and implement PCMH+-related requirements. PCTMF did not submit any documents pertaining to their work with CYSCHN and did not submit any CYSHCN files for review.
- PCTMF began reporting the number of CYSHCN t in January 2019. PCTMF is developing processes to flag and track the number of IEPs and 504 Plans collected in the EMR. PCTMF has not provided this information on the monthly reports since the start of Wave 2.

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

- PCTMF is developing processes to address the needs of members with disabilities as a specialty population under the PCMH+ program and implement PCMH+-related requirements. PCTMF did not submit any documents pertaining to their work with members with disabilities and did not submit any files for review.
- PCTMF has defined members with disabilities as members with the presence of the following DRG medical code(s): H54 (blindness), H911 (hearing loss), Z74 (impaired mobility), Z99.3 (wheelchair) and F41.8 (situational anxiety). The use of DRG codes may be limiting the number of members with disabilities identified for care coordination services.
- PCTMF began reporting the number of members with disabilities in January 2019 but has not reported the number of members who have received adjusted appointment times.
- PCTMF is working to standardize how providers document the unique needs of members with disabilities. Documentation of these needs has been provider-dependent and PCMTF recognizes the importance of standardizing this process.
- PCTMF has not implemented mandatory staff disability competency trainings. They recognize this as an area of growth.
- All of PCTMF’s facilities are Americans with Disabilities Act compliant. They offer larger bariatric rooms for members who utilize wheelchairs, have bariatric scales, hi-lo tables for members with mobility challenges, utilize language lines and telehealth for members who speak American Sign Language.
- PCTMF is exploring options to offer written materials in braille and large print for members with visual impairments.

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

- PCTMF staff receive cultural competency training during new staff orientation as well as annually. Training is provided through Health Stream and does not address the needs of member with disabilities.
- The member file review did not contain evidence that PCTMF assesses members for cultural needs or preferences.
- PCTMF did not provide plans of care for the members submitted for the member file review. No evidence of assessment of cultural needs or preferences could be found.
- PCTMF has not implemented CLAS standards.

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

- PCTMF has implemented a phased strategy to address SDoH. Phase 1 includes engaging members to assess for SDoH, Phase 2 includes staff training on the impact of SDoH and Phase 3 includes the standardization of processes to support a consistent approach to implement and assess impact and progress. Phase 3 also includes embedding SDoH questions into the EMR, educating remaining staff and developing reports to assess progress. PCTMF is in Phase 1 of their strategy.

- As part of the onboarding process, PCTMF staff are oriented to member education resources, including referral resources for community linkages that address SDoH.

- PCTMF has established multiple 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 food pantries, home delivery meal services, services for individuals who are elderly, housing supports and legal assistance.

- PCTMF care coordinators use a TCM progress note template which includes prompts for SDoH. Elements assessed include: Social services and community supports, family or social supports to assist with management of health care, access to transportation, sufficiency of food, ability to pay monthly bills.

- Results of the member file review indicate that some members are screened for SDoH, but not all. When a SDoH is identified, there is limited evidence that the community health worker works with the member to resolve the issue.

- PCTMF has a high rate of members declining or refusing care coordination (as high as 45 members per month). For those members who declined or refused care coordinator services, SDoH assessments are not complete.

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

- PCTMF did not submit a full sample as requested. PCTMF reported that they have elected to focus efforts on the adult population and did not submit files for CYSHCN, Transition Age Youth and individuals with disabilities. PCTMF submitted only 15 files for review. PCTMF did not submit demographic forms, diagnosis lists, plans of care and results of BH screenings in any of the member files. Reviewers included two Mercer representatives who reviewed a total of 15 member files. As part of the onsite review, Mercer requested to look at files to determine if information was present that was not readily found within the desk review submission. The focus was on evidence of a BH screening, asking about psychiatric advanced directives, assessing for cultural needs and preferences and SDoH.

- PCTMF's current care coordination model focuses on reduction of readmissions for members who have been discharged from an inpatient medical or BH admission. The care coordinators use a standard internal template for TCM. The template is completed for anyone discharged from an inpatient medical or BH unit.

- Most members only receive three calls as required per PCTMF community health worker documentation and assistance is limited to the scope of these calls.

- There are two hospital systems used by the PCTMF's PCMH+ members: Waterbury and ECHN (Manchester and Rockville). Waterbury uses Cerner as their EMR and ECHN uses Meditech.

- Providers use Allscripts as their EMR but they use different versions. The care coordinators only have access to certain parts of the record. In addition, care plans are housed in an internal case management software called Essette.

- Due to the limitations of the system interface, most of the PCMH+ elements could not be validated.

Behavioral Health/Physical Health Findings

- For members with BH conditions, the records only contained care coordination notes and there was no evidence of coordination with BH providers.

- PCTMF did not provide evidence of universal BH screening, including screening for substance use disorders. There was some evidence in the social section of the ECHN files of asking about

alcohol and substance use but no demonstration of identifying potential misuse or making a referral. The patient manager section of some charts contained evidence of PHQ-9 screening.

- PCTMF did not provide evidence of assessing members for the presence of a psychiatric advance directive or a Wellness Recovery Action Plan.

Cultural Competency Findings:

- PCTMF did not provide evidence of assessing members for cultural needs and preferences.

Community Linkages Findings:

- PCTMF's community health workers conduct an assessment of SDoH with some members, but not all. When an assessment is completed, elements assessed include: Social services and community supports, family or social supports to assist with management of health care, access to transportation, sufficiency of food and ability to pay monthly bills. When a SDoH is identified, there is limited evidence that the community health worker works with the member to resolve the issue.

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

PCTMF arranged two interviews with PCMH+ assigned members, all were face-to-face interviews.

- Both members were receiving PCMH+ enhanced care coordination interventions, which was confirmed by PCTMF.

- PCTMF has not held an advisory board meeting but both members showed interest in attending and being a part of the board. Both members explained the importance of "advocating for themselves and other members that might be going through what they are going through." One member stated that "every voice helps."

- None of the interviewed members had issues accessing medical care. The members agreed that their providers show an interest in their care. Each of the members felt very comfortable voicing their opinions and/or disagreeing with their provider if needed. One member stated that he had been given different contact numbers for different situations that he could call if an issue arose but said that he would likely just call his care coordinator for assistance.

- 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 contacted by their care coordinator after their hospital discharge and noticed a difference in their care experience due to the care coordinators interventions. These care coordinators educated these members on available services such as assistance with housing, home aides, diabetes program (which offers support with medication and diet), food banks, transportation, etc.

- One member expressed his gratitude for his care coordinator stating that “he was the light at the end of the tunnel.” He stated that “his care coordinator was a professional but also let his human side show.” The member went on to say that “it really makes a difference talking to someone who is going to assist you with your medical needs but who also asks about your family and how your life is going.”

- Another member stated that “he now has the courage to speak up for himself and with his care coordinator’s help things are getting done better and quicker.”

APPENDIX A

PROSPECT CT MEDICAL FOUNDATION RECOMMENDATIONS FOR IMPROVEMENT PLAN

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
Program Operations	PCTMF is using multiple EMRs across hospital systems, BH providers, PH providers and care coordination documentation is not currently integrated into the EMRs. Care coordinators only have access to certain parts of the medical record and care coordination notes are faxed to providers. Care plans are housed in an independent case management software called Essette.	Develop a plan to improve information-sharing across EMRs and standardized documentation procedures to improve coordination of care for all members. Consider the use of templates that may be used within all EMRs that will result in standardized documentation.
	Five newly acquired practices do not hold PCMH recognition. A work plan is being developed to bring these practices under PCMH recognition by 2020.	Provide an update to DSS on the status of PCMH recognition for sites pending recognition with target dates.
	PCTMF will not hold their first oversight body meeting until April 2019.	Formalize procedures to ensure substantial representation of PCMH+ member attendance at Member Advisory Board meetings and meet the requirement to hold meetings on a quarterly basis at a minimum.
	PCTMF has demonstrated a low penetration rate of less than 1%.	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.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
	PCTMF's current care management workflow limits care coordination to high-risk patient transitions of care from the acute hospital to home, or skilled nursing facility to home, direct provider referrals or by risk stratification data. This current model of care may be contributing to a high rate of members declining care coordination services and/or the low penetration rate.	Consider expanding the availability of care coordination services beyond members considered high-risk following a transition of care.
	PCTMF's monthly report contains inaccurate information and is not completed in its entirety.	Ensure all tabs in the monthly report contain accurate information on a month-to-month basis.
	PCTMF is developing a quality program plan to fully implement PCMH+ quality requirements.	Develop a quality plan with addresses PCMH+ quality requirements.
Under-service	PCTMF does not have an under-service policy or methodology that monitors for, identifies, and addresses under-service and access to medically necessary care.	Develop an underservice methodology to monitor, prevent, and address under-utilization of clinically appropriate services that may be shared with DSS as requested.
Physical Health-Behavioral Health Integration	BH and PH EMRs are completely separate and member information is not shared bi-directionally between behavioral and medical providers. PCTMF is researching system integration methods to improve care coordination efforts.	Develop a plan to improve information-sharing across BH and PH EMRs to ensure coordination of care for BH members.
	Based on the member file review, there was no evidence that PCTMF develops plans of care for members with BH conditions. Files for BH members contained limited care coordination notes and did not demonstrate coordination between BH and PH providers.	Develop standardized documentation procedures for plans of care and care coordination activities for BH members.
	PCTMF is developing a universal BH screening process.	Formalize procedures to promote, implement and document the results of universal BH screening, including screening that goes beyond depression and anxiety.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
	PCTMF is developing a process to assess members with advanced psychiatric directives and inclusion of directives in the member file.	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.
	PCTMF is developing processes to assess members with wellness recovery action plans and inclusion of the plan in the member file.	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.
	PCTMF is developing processes to query multiple EMRs to meet the monthly PCMH+ reporting requirement on the number of psychiatric advance directives and Wellness Recovery Action Plans conducted and/or collected on PCMH+ members.	Formalize procedures to report counts of members with psychiatric advance directives and Wellness Recovery Action Plans on monthly reports.
	PCTMF is developing processes to meet Transition Age Youth program requirements.	Develop a process to identify Transition Age Youth to prompt for transition of care support.
Children and Youth with Special Healthcare Needs	PCTMF is developing processes to meet CYSHCN program requirements.	Formalize procedures to define, identify and develop advance directives for CYSHCN.
	PCTMF is developing processes to track and extract the number of individualized education plans (IEPs) and 504 Plans collected from the EMR for the monthly report.	Formalize processes to collect school information, including IEPs and 504 Plans where applicable, for incorporation into the member's plan of care.
	PCTMF is developing processes to address the needs of members with disabilities as a specialty population under the PCMH+ program.	Formalize procedures to report counts of IEPs and 504 Plans collected on monthly reports.
Competencies Caring for Individuals with Disabilities	PCTMF's definition of members with disabilities is limited to members with the presence of certain Diagnosis Related Group (DRG) medical codes. This may be limiting the number of members with disabilities identified for care coordination services.	Consider expanding methods to identify members with disabilities beyond DRG medical codes to increase the number of members with disabilities who may be identified for care coordination services.

REVIEW AREA	OPPORTUNITY	RECOMMENDATION
	PCTMF is developing processes to track and extract the number of members who have received adjusted appointment times from the EMR for the monthly report.	Formalize procedures to report counts of members who received an adjusted appointment time on the monthly reports.
	PCTMF is still developing standardized documentation procedures regarding the unique needs of members with disabilities.	Formalize documentation procedures to incorporate the unique needs of members with disabilities into the EMR and plans of care.
	PCTMF has not yet implemented mandatory staff disability competency trainings	Develop a training plan to train staff on the unique needs of members with disabilities.
	PCTMF is exploring options to offer written materials in braille and large print for members with visual impairments.	Formalize procedures to ensure written materials are readily available and accessible for members with visual impairments.
Cultural Competency	PCTMF is developing processes to assess members for cultural needs and preferences.	Formalize procedures to assess members for cultural needs and preferences.
	PCTMF is developing processes to incorporate member cultural needs and preferences in the plans of care.	Formalize procedures to incorporate member cultural needs and preferences in plans of care. A standardized template may assist with incorporation of these elements into the plan of care.
	PCTMF has not integrated culturally and linguistically appropriate services (CLAS) into the organization.	Develop a plan to integrate CLAS standards into all levels of the organization.
Community Linkages	PCTMF does not screen all members for SDoH.	Formalize procedures to ensure consistent screening for SDoH within the PCMH+ population.
	PCTMF does not have a standardized documentation process to demonstrate that community health workers work with members to resolve SDoH.	Formalize standardized documentation procedures for work pertaining addressing and resolving SDoH.

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